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ABSTRACT

The 73 participants representing 10 health professions, health education at all levels, and federal and state agencies attended a 2-day conference which attempted to reinforce communication among allied health practitioners in the utilization of the allied health assistant in the delivery of health care. Major issue papers, which provided discussion ideas for multi-disciplinary workshops, were: (1) "Health Manpower and the Health Crisis" by K. M. Endicott, (2) "The Assistant: Mobile or Immobile?" by J. W. Perry, (3) "The Assistant's Basic Education" by Sister A. Joachim, (4) "The Need: Who? When? Where?" by L. M. Detmer, and (5) "Certification and Licensure: Blessing or Boondoggle?" by E. E. Leuallen. Needs of selected disciplines were also recognized, and these become the major area of concentration in the panels and disciplinary workshops. Texts of the major papers and workshop notes are included in the report. (SB)

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**MANPOWER CONFERENCE
ON ALLIED HEALTH
PROFESSIONS ASSISTANTS**



**SCHOOL OF
HEALTH RELATED PROFESSIONS**

**Faculty of Health Sciences
State University of New York at Buffalo**

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STATE UNIVERSITY OF NEW YORK AT BUFFALO
SCHOOL OF HEALTH RELATED PROFESSIONS

DISTINGUISHED LECTURE — 1970
INVITATIONAL MANPOWER CONFERENCE

EDITED BY: Frank L. Husted and J. Warren Perry

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INTRODUCTION

A common criticism that has been leveled at physicians is that they have not been trained to understand, appreciate, or know how to utilize the professional capabilities of other members of the health team. Whether this is valid or not, it has become increasingly evident that with the steady emergence of health manpower from the two-year programs, a similar critical comment can be focused on the fact that allied health professionals also have not been trained to understand or know how to work with the assistant level of worker. Thus, this conference attempted to reinforce important avenues of communication among allied health practitioners representing ten health professions, health educators at all levels, and federal and state representatives on this priority issue: the utilization of the allied health assistant in the delivery of health care.

The members of this faculty and many upper-division students worked closely with the Institute Planning Committee in implementing the objectives of this conference. It was especially good to have so many of our "national" friends join us here in Buffalo, and the registration listed over 350 participants. I want to record here my special appreciation to Frank Husted, Joseph Nechasek, Gail Ryan, Marjorie Tiedemann, and Madeleine Waters. Without their untiring efforts, this program would never have reached fruition.

All in all, this conference illustrated in a very real way what being "allied" can accomplish.

Buffalo, New York 1970

J. WARREN PERRY, Ph.D., DEAN
School of Health Related Professions
Professor, Health Sciences Administration

Health Related Professions Distinguished Lecture Program

The Health Related Professions Distinguished Lecture program was inaugurated in 1969 to bring to the Buffalo community a national leader to speak on health professions education and health services.

1969—Mary E. Switzer, Administrator, Social and Rehabilitation Service, Dept. of Health, Education, and Welfare, Washington, D.C. (In 1970, Miss Switzer left that post to become Vice President of the World Rehabilitation Fund, and special consultant to the Association of Schools of Allied Health Professions in Washington, D.C.)

“Changing Missions for the Helping Professions”

1970—Kenneth M. Endicott, M.D., Director, Bureau of Health Professions, Education, and Manpower Training, National Institutes of Health, Bethesda, Maryland.

“Health Manpower and the Health Crisis”

The Distinguished Lecture, delivered on April 15, 1970 was the keynote address for the Conference on the Utilization of Allied Health Professions Assistants.



Distinguished Lecture—1970

KENNETH M. ENDICOTT, M.D.

*Director
Bureau of Health Professions Education
and Manpower Training
National Institutes of Health*

“Health Manpower and The Health Crisis”

I am happy and honored to meet with you on this occasion and to share with you some of my thoughts on the widely acknowledged crisis in health care and service throughout our Nation.

For, as reported by the President, Secretary Finch, Assistant Secretary Egeberg, and many national organizations, there is indeed a health crisis. There is a massive shortage of physicians, dentists, nurses, and all types of allied health personnel. Unless very substantial investments are made by all concerned to expand the educational capacities of our health professions schools now, these serious shortages will persist into the late 1970's and even into the 1980's.

As Secretary Finch said last autumn, “The crisis . . . is many sided. It is a crisis of escalating costs . . . of inadequate facilities . . . of flaws in resource distribution . . . and, at the very core, interlocking with all the other aspects, it is a crisis of manpower. The right categories of manpower — in the right places — in adequate numbers — and at the highest standards of excellence.”

So it is clear that we are going to be challenged during these next few years — years that will continue to be marked with many competing demands; but, if we truly commit ourselves to the substantial investments needed of our resources, our energies, our time, our leadership, and our cooperation — if we will invest all these, we will meet the challenge.

I understand that the participants in this conference include an impressive portion of the State University of New York at Buffalo as well as distinguished educators from other parts of the nation, leaders from many professional organizations, directors of health-care programs, and a couple of other federal health-program people. The latter two may find it difficult to conceal their presence if I should happen to mention some of the frustrations back in Washington "up with which we have to put." But, seriously, this group represents a fair cross-section of the different kinds of expertise and resources that should help us meet the challenge of the nation's health crisis.

It seems to me that each of you is here to gain some additional insight into our common problem; naturally, you expect to build upon knowledge and judgment already acquired. May I caution you to avoid the blunders of the past, as experienced not only in your own fields, but also in those others that have felt the heat of the public spotlight upon them. We don't want to go stumbling into the future; we need to retain flexibility in our plans and in our attitudes so that we can adjust to the developing needs of the future.

As you develop plans for the training and the roles of emerging allied health professions assistants, I believe you will discover that you will have many of the concerns and problems that are common to new parents, who are naturally proud and cocky, but also insecure and over-protective. Mistakes made, either innocently or not, by their own parents are fresh in their minds; and these new mothers and fathers are *determined* that they shall not commit those same mistakes. However, because they often are unknowledgeable of alternatives, they do indeed perpetuate those things that they wanted to eliminate.

For example, as the shortage of physicians has become increasingly evident, there have been admirable efforts to define or to establish new kinds of health personnel, whose training could be shorter and less costly, who could assist the physician in caring for more patients. None of these efforts has really jelled yet, although some have been more successful than others, and all have elements of value. I am sure you are aware of the problems that the concept of the physician's assistant has faced — accreditation, licensure, liability insurance, hostility from other established health professionals, incomplete acceptance by consumers, and so on. So, we must learn from the past; and we must avoid hardening of our attitudes.

The most important consideration in the development of new assistants should be the enhancement of patient care, and it should be high-quality care delivered more efficiently and more

economically to more people. The least important consideration would certainly be prestige enhancement of the health professional. The common theme throughout the continual development of new assistants should be flexibility; and it is heartening to me that all of the pending allied health legislation that is before the Congress carries this common theme. Each new program and each new kind of assistant should be judged on its own merit of meeting the needs of people both before and after they become patients.

There are so many other considerations in developing a new cadre of assistants. Who will train them? Who will train the faculty? Where should training occur? Are equivalency and proficiency examinations planned?

Faculty shortages and limited facilities, particularly, emphasize the need to coordinate educational efforts of several different professional areas and to develop core curriculum. Needless duplication and fragmentation of efforts must be avoided to conserve our limited resources.

A lot of words have been written and many speeches delivered on the subject or concept of the health-team approach to medical care. They all boil down to the need to recognize that each health professional has a piece of the action in preventing illness, treating disease, and providing care; each health professional must recognize this and accord his colleagues the same recognition he desires.

One of the most important objectives of all the educational programs administered by the Bureau of Health Professions Education and Manpower Training has been the advocacy of the health-team approach not only to health and medical services, but also to the setting for the education of all health personnel. I am delighted to see this concept being fostered by this conference.

The development of health manpower educational centers will produce many benefits. Education and training will be carried out in the most effective and efficient period of time, in settings most appropriate and relevant to the level of skill and judgment required by the job or profession. A flexibility will be provided that will be responsive to changing and evolving requirements for the delivery of health services. Innovation will be encouraged in the organization of educational and training programs. Students will be more able to adapt to changes as they take place in the occupations for which they were originally prepared.

One of the most important benefits from health manpower educational centers, however, will be the recognition by each

health discipline of the contributions of all the others; this awareness will be instilled from the first day of training and will be enhanced through continuing contact and cooperation. I want it to be very explicit that I think these centers should encompass the education of medical students, interns, and residents as well as nurses, dentists, and the whole array of allied health personnel.

One of the most important needs of these centers will be faculty, specially trained in the accelerating developments that exist in all aspects of preparing health manpower that, in turn, will provide health services that will reflect increasingly revolutionary changes in the concepts of health maintenance and protection. Preparation of such faculty has the highest priority of the health manpower bureau; and it is my hope that it will be yours.

To assure the continuing interest and motivation of health professions students, efforts should be increased to provide maximal transfer of credits between educational institutions. To assure the achievement of an optimal education for these students, local employers should be invited to consult with educational planners. Your responsibility will be to provide leadership in all these endeavors.

Through these developmental projects in educational settings, we can support curricular modifications to meet the special needs of students with backgrounds of socioeconomic disadvantage or students with previous health training such as returning medical corpsmen. We can also promote curricular development for training in new health services that result from evolving technology or realignment of duties among the health disciplines.

Interrelationships and cooperative planning among educational institutions and health-service programs must be actively sought and strengthened. Through these linkages we can strive to improve the skills and judgment of all health personnel. We can also provide for vertical and horizontal mobility of these workers. Continuing opportunity is an essential component of high motivation and dedication to a health career.

Other innovative methods for closing the manpower gap have been discussed by various leaders and educators. Year-round classes would not only shorten the training period, but would probably have great appeal to many of our action-minded young people. The summer recess is a remnant of our outdated agrarian economy.

Many lecture halls and laboratories are incompletely utilized. The rotational use of these facilities would help meet our health

crisis. Neither should we be content with determining these untapped resources just in the same old, familiar places. Many communities and many large industrial concerns provide meeting places for ladies' groups and service clubs; the didactic education of health personnel could just as well proceed in such a setting.

In metropolitan areas, a consortium of several schools could accommodate their students in basic science training much more economically in one centrally located educational facility. There are other alternatives as well; one school could focus upon biology; another, chemistry, and still another, physiology. All students, under such arrangements, could probably receive higher-quality training at less cost than if each institution tried to provide all of these disciplines on their individual campuses.

The patterns of training and utilization of allied health personnel should continue to be numerous and to show variations. Now, early in the effort to train new kinds of health workers, the struggle among these varying patterns will allow freedom for experimentation and confrontation of their virtues and weaknesses; the struggle is healthy and will produce conclusions tested in the fire. Otherwise allied health education and training programs will become rigid before they mature and thus will become incapable of responding to changing patterns of care due to advancing knowledge and improved technology.

As in any social development that progresses at a rapid pace, issues and problems are bound to emerge. Groups such as this should assume the responsibility to identify these concerns and problems so that they do not become major roadblocks in the path of changing patterns of care and training.

Educational institutions need to develop a balance between basic and specific training. The pressure of local employers should be resisted to train workers to do specific jobs only. These very specialized tasks lock workers into narrow, dead-end jobs, not health careers; furthermore, such workers soon become discontented and cease to function at their highest capability. There is a great deal of evidence that many changes will occur in the health service industry in the next ten years. These innovations will involve various kinds of manpower changes — including new duties, totally new jobs, as well as many new forms of automation that will still require skilled technicians. It is therefore relevant to inquire whether the education being provided or even planned now will be responsive to future needs.

There can be no question that people learn in many settings other than the classroom, and this is also true in the health occupations. We need to examine whether knowledge acquired

nonacademically is equivalent to that learned in a formal academic program; this is particularly so in the allied health field. The need for equivalency examinations for the health occupations, as for others, is based on the premises that: 1) Students should not be required to repeat work that they have already mastered. 2) The objectives of college course-work can be achieved in other than classroom settings. 3) The acquisition of knowledge and skills can be measured by examination. 4) The results of these examinations can be used by colleges to determine whether advanced placement or academic credit should be awarded for previous learning and experience. Thus, equivalency examinations have far-reaching implications for health manpower shortages and for career mobility.

Any discussion of health related or allied health careers must take note of the new careers movement. The concept of new careers, developed through programs of the U.S. Department of Labor and the Office of Economic Opportunity, supports the position that the health service industry needs employees and that among the economically and culturally disadvantaged are a pool of unemployed and underemployed persons, many of whom can make significant contributions if provided with the proper training. This position acknowledges that the disadvantaged have been educationally neglected and that innovative methods geared to their special needs should be adopted. The new careers concept is a partial answer to both the problems of unemployment and poverty and to the needs of the health field.

A basic principle of this new program stresses that the disadvantaged should be screened into the health field. For example, a high-school dropout should first be given opportunities to assist in the simplest tasks in as wide a variety of services as possible. Another principle emphasizes the need for remedial education, particularly in those subjects that will help the individual pass the high-school graduate equivalency examination. The new careerist, at this point, will be working at the aide level; but after a specified period and demonstration of required skills, he should be given a wage increase and assigned to an occupation in which he is interested and in which he shows reasonable competence.

After acquisition of the high-school graduate equivalency diploma, the new careerist should be enrolled in a junior college health occupations curriculum. He should receive released time from his job. All the while, opportunities should be provided for flexibility in his assignments at the hospital or health center; and the core curriculum should offer additional exposures to other occupations. At the conclusion of his second or third year, depending upon the amount of time divided between work and

study, the new careerist will have achieved technician status in a specific occupation.

While working as a technician, he should be able to enroll, if he chooses, in a baccalaureate program to become a technologist. Or he can take continuing education courses and thereby qualify for advanced status. The general pattern then is one of career mobility and built-in educational and training opportunities to raise individuals from entry level to technician to technologist, and on to professional status according to the ability of the trainee.

There is also a good deal of ferment these days about geographic mobility, because requirements such as licensure, accreditation, and certification present obstacles to the equitable distribution of health manpower. These requirements are generally considered, as one educator has described them, as "property rights;" but their value to our society generally must take first priority or other means — perhaps, less satisfactory — will be devised. These factors have a significant impact on national goals; and we must keep progressing toward the accomplishment of the expectations we have raised — adequate health care for all of our people.

The need for qualified allied health personnel is severe. Today, a 29 percent deficit exists between the nation's supply and requirements for allied health manpower; by 1980, the deficit is expected to be 32 percent. As we grapple with the monumental task of producing enough trained health personnel, we become increasingly aware of how dependent the health system is on those professional, technical, and supportive health workers who extend the scarce resources of the professional health administrators and practitioners.

The full benefits to be gained from provision of services for which allied health personnel are particularly capable can be realized, however, only if there is adequate support for educational resources that will attract able students and prepare them for meaningful health careers. Within the context of the self-evident need for more allied health workers, I would like to examine our several roles in the support of this enterprise.

Funding for these educational resources will continue to be primarily a state and local responsibility. Available federal dollars are not expected to be sufficient, even on a matching basis, to narrow the gap between the supply and need of other health professionals whose training is longer and costlier; therefore local dollars will have to foot the major part of the bill for allied health training.

However, as you know, students in the allied health fields

have received aid under the Vocational Educational Act and the Manpower Development and Training Act, administered by the Office of Education and the Department of Labor. Regional Medical Programs and other special mission-oriented health programs also have contributed significantly to the allied health training effort.

The Allied Health Professions Personnel Training Act of 1966 was the first Federal legislation specifically designed to increase the number of allied health personnel and to improve and expand allied health education and training. Four types of assistance were authorized by the Act — construction of teaching facilities; improvement and strengthening of educational programs; preparation of teachers, administrators, supervisors; and development of new methods and curricula for new kinds of health technologists and technicians. Limited funds available for the implementation of the Act were factors in the decision to give initial priority to those allied health occupations most directly related to patient care and to those for which shortages were most fully documented.

Experimentation and demonstration in education and training of allied health personnel must be pursued energetically, but with a high degree of professionalism. Irrational, unscientific, and unsophisticated attempts to introduce training programs for new types of health personnel must be diligently discouraged by educators, health manpower planners, and all others who have responsibilities for the education, training, and utilization of health workers. Proliferation of occupational categories without sound reasoning would only feed the flames of chaos already fanned by years of neglect during which jobs, job descriptions, and training have been created to meet immediate, local needs without considering the feasibility of replication in other settings.

The demands to increase the supply of qualified health manpower in the decade ahead will require cooperation of the highest order among the various groups and institutions interested in the training and increasing effectiveness of health personnel. The time has come for an interface among all interests in the health sector of our society. It must be candid. It must be professional and without pettiness. It must be motivated by an honest desire and intention to take action that will result in dynamic, yet orderly progress toward meeting the Nation's health manpower needs.

We need to be wary of committing the sort of pseudo-omniscience that Dr. Raymond W. Mack, a sociologist of Northwestern University, once illustrated with this "throw-away" line: "We are both doing the Lord's work — you, in your way; I, in His!"

PROGRAM

Invitational Manpower Conference

Utilization of the Allied Health Professions Assistants in the Delivery of Health Care

Crystal Ballroom — The Executive Ramada Inn

THURSDAY, APRIL 16

Chairman: Frank L. Husted

8:00- 9:00	Registration and Coffee
9:00- 9:15	Welcome—Daniel H. Murray
9:15- 9:30	Aims & Objectives—Frank L. Husted
9:30-10:00	J. Warren Perry "The Assistant: Mobile or Immobile?"
10:00-10:30	Sister Ann Joachim "The Assistant's Basic Education"
10:30-11:00	L. M. Detmer "The Need: Who? When? Where?"
11:00-11:30	Elliott E. Leuallen "Certification and Licensure: Blessing or Boondoggle?"
11:30- 1:00	Lunch Recess
1:00- 4:30	Multidiscipline Workshops

CHAIRMEN

Carpendale, Michael
Carter, Richard
Chapman, Charles
Cossoy, Barbara
Karni, Karen

McTernan, Edmund
Owens, F. Robert
Pascasio, Anne
Peake, Laurence
Robinson, Ruth

FRIDAY, APRIL 17

Concurrent Panels 9:00 a.m.-12:00 noon

PANEL I	Moderator: Veronica Conley	
9:00- 9:30	Medical Technology	
		Roma Brown
9:30-10:00	Medical Records Librarian	
		Myra Enkelis
10:00-10:30	Dietitians	
		Katharine Manchester
10:30-11:00	Dental Hygienists	
		Patricia McLean
11:00-11:30	Radiological Technology	
		Marjorie Tolan
PANEL II	Moderator: Thomas Hatch	
9:00- 9:30	Physical Therapy	
		Robert Bartlett
9:30-10:00	Occupational Therapy	
		Arlene Mellinger
10:00-10:30	Rehabilitation	
		Marceline Jaques
10:30-11:00	Nursing	
		Ruth McGrorey
11:00-11:30	Home Health Aides	
		Harry Sultz
11:30- 1:00	Lunch Recess	
1:00- 3:30	Discipline Workshops	
Panel Plenaries		
3:30- 5:00	Panel I — Veronica Conley	
3:30- 5:00	Panel II — Thomas Hatch	



FRANK L. HUSTED

*Conference Chairman
Associate Dean,
School of Health Related Professions,
State University of New York at Buffalo**

The Aims, Objectives and Format of The Invitational Conference on The Allied Health Professions Assistant

The faculty and staff of the School of Health Related Professions of the State University of New York at Buffalo has long been interested in and concerned about the education and utilization of the allied health professions assistants in the delivery of health care. The warm, productive and close relationship the School has enjoyed with local and national community colleges through its community college teacher preparation program and through continuing personal contacts with hospital based programs stands as concrete evidence that this concern has been more than casual. It was in this fertile soil of interest and action that the need for two or three days of concentrated interaction between nationally prominent allied health educators, workers, students and interested administrators took root and grew into the recently concluded Invitational Manpower Conference on the Utilization of Allied Health Professions Assistants in the Delivery of Health Care.

The aims and objectives were relatively simple and were directed to providing an opportunity for others as deeply concerned to discuss the issues from the general framework of

*On July 1, 1970, Dr. Husted will become Dean of the College of Allied Health Professions, Temple University, Philadelphia, Pennsylvania.

mobility, education, need and recognition and from the specific references indigenous to some of the disciplines deeply involved in the day-to-day problems of utilization.

The format was one in which major issue papers were presented to all participants and then, in mixed-discipline workshops, each was given an opportunity to speak and to hear others speak to the major issues. The needs of each selected discipline were recognized and these became the major area of concentration via panels and discipline oriented workshops on the second day.

This document, then, is intended to present the deliberations of the two days in their purest form. Actual papers are reproduced, workshop notes are presented with a minimum of editorial input to preserve the essence of issues, problems, resolutions, dynamics and recommendations; and the action section which concludes the document is a compilation of statements extracted from the proceedings and which seem to point the way for change in the months to come.

The Chair most warmly extends thanks and appreciation to the speakers, chairmen, recorders, coordinators and the secretarial staff for the splendid response, cooperation and hard work which is, in truth, responsible for the successes realized. Appreciation is also extended with pleasure to the financial sponsors — the Regional Medical Program of Western New York and the United Health Foundation of Western New York.



J. WARREN PERRY

*Dean
School of Health Related Professions
State University of New York at Buffalo*

The Assistant: Mobile or Immobile?

"Suit the action to the word, the word to the action."¹

The role of a dean these days can be a thoroughly hectic experience, and yet the rewards at times can be so special that all other vocations seem pale by comparison. This conference is a case in point. For some time now, several members of this faculty have been searching for a suitable follow-through to our 1967 Buffalo Manpower Conference for the Health Related Professions. Thus, when Frank Husted and members of our faculty shared with me their desire to convene this invitational conference based upon the subject of the utilization of the allied health assistant in the delivery of health care, I must admit that I was "turned on" immediately. Though we have many challenges facing us, I can imagine no more important subject on which to focus attention and energy than this issue of utilization of the allied health assistant.

A favorite pastime of speakers today in viewing the obvious health manpower crisis is to accuse physicians and dentists of failing to understand and appreciate the important role that allied health professionals might take in the health delivery system of today and in the future. It is an easy and popular charge to make, and one that I must admit that I have employed with a great deal of personal satisfaction and vindictiveness. But as I thought about the role of the allied health assistant, I realized

¹ Shakespeare, W., "Hamlet", Act III, Scene 2.

that my own words could return to haunt me, for I am convinced that there is validity in the assumption that some of the health professions represented at this meeting share in the guilt for not having carefully defined and delineated the real function of the allied health assistant in health care services.

Hundreds of community colleges and technical institutes are in the process of creating programs which will train a magnitude of health manpower at the Associate degree — "the assistant" — level scarcely dreamed of several years ago. Creating new health occupational levels, as has been done in the development of these "assistant" programs, carries with it a major responsibility . . . a responsibility which the professional allied health group and the institution must share. Each year that responsibility becomes more acute as new programs are begun and more health fields delineated, for we must never forget that the patient is the one who must ultimately be the consumer of our creative acts today. The patient will be the judge and evaluator of these new members of the health team.

Need for Career Mobility

Why has there been so much discussion in the past few years about the concept of career mobility? Educators, as well as enlightened professional workers, recognize that closed doors and dead ends have been ever present in many if not all of the allied health occupations.

Serious, constructive steps have been taken in some of these fields to spell out the specific roles and job functions of the aide and the assistant categories of workers. Educational criteria or essentials have been developed in some cases for the community junior colleges charged with setting up training programs for allied health.

But the dead ends of occupational movement at especially the lower levels spell problems in job satisfaction, a curtailment of material rewards, and, more importantly, a dwindling of motivation and initiative to perform the highest level of individual service function on the job.

We must not accept that the high percentage of women with marriage and the family on their minds is always the motivating factor for increasing incidence of occupational "drop-outs" from health occupations, transfer from job to job in clinical facilities, and considerable dissatisfaction with delegated responsibilities. When a gate is slammed shut in your face, you either have to attempt to open it, climb over or under, find another means of entry, or just withdraw from the situation. In far too many instances, a closed door in a health job has meant a permanent

loss to the health manpower pool.

As this sophisticated audience knows, the need for career mobility has been conceptualized by the symbol of a ladder and a lattice. Recently at a meeting, I was introduced as one of the original "carpenters" for having encouraged the "building" of these mobility concepts in health careers. Each is quite explicit: (1) The ladder describes the potential for educational and occupational movement in a vertical, upward thrust that might make it possible, based upon completion of educational requirements, measured capabilities and clinical experience, for an individual to move vocationally upward. There are those individuals who have proposed that this should first of all be possible within a specific allied health profession and others who contend that there is a core of health content that might make this movement possible for a professional nurse or physical therapist, to name only two examples, to move into medicine, or a dental hygienist into dentistry, without necessarily tripping down a rung or two on the ladder before the ascent to the top of the educational or professional field. (2) In addition to the ladder concept, the "lattice" concept in health careers has been described. This purports that in addition to the vertical-movement theory in a health field, there should be provided a possibility for the horizontal or lateral transfer between health professions, and, specifically, allied health professions. Entry would not be at the lower level of the ladder or lattice, but with recognition of educational and occupational experience common to several health fields, entry to a new health career would be relatively easy to achieve by such lateral movement.

Factors in Career Mobility for the "Assistant"

If any measure of career mobility will become reality in educational programs and in vertical and/or horizontal occupational movement in the clinical setting, there are certain factors which must be given priority attention. I will gear my comments here specifically to the role of the allied health assistant.

1. Job analysis and job description come before the initiation of new curricula. In both educational and vocational mobility, the primary task must relate to a careful job analysis for which the student is being prepared. It seems to me that much more time and energy has been expended on the development of new curricula rather than on a careful analysis of how the product of the program . . . the student . . . is to be utilized as a health worker.

One of the major challenges to the creation and development of a new occupational field at the level of the "assistant" is

to be certain that a thorough job description has been written and a comprehensive job analysis has been developed. This has been one of the major problems in the allied health professions, for job duties and occupational role have not been defined for all of the fields which clearly spell out the relationships between the role of the allied health professional and the role of the allied health assistant, or the hospital-trained technician, or the role of the aide. This can be done only upon the basis of job analysis, and until this kind of thorough, painstaking study of occupational functioning is done it is impossible to develop different levels of curriculum with maximum effectiveness. In most cases, those of us in the health fields need expert help and advice on this area for it is not as easy to accomplish as it might seem. This level of occupational analysis with a minute attention to role and function demands the time and efforts of occupational and job analysis specialists.

I am sure that there is some justification for the position that manpower shortages are so acute that there just isn't enough time to communicate with the entire health field about the specific needs of the individual health field. Yet I believe that thoughtful analysis of the role of the assistant must be given priority attention if these health workers are ever to be successfully integrated into the fabric of the health care delivery system. It is no secret that negative cries and strong reactions have arisen from the ranks of the baccalaureate graduates and the hospital-trained technicians concerning the graduates of the Associate degree programs. Those days of protest will come to an end only when we get down to work and prove how the mobility issue, both educationally and vocationally, can be resolved.

2. Educational programs in the community college must be designed with statements of objectives and evaluation of role, functions, and duties to match the prepared job descriptions and analyses. Without this kind of orderly analysis, we will never be able to differentiate the various levels of proficiency, levels of performance and responsibility on which to base the educational programs already in existence and those yet to be planned.

3. Equivalency testing has been one of the most talked about "panaceas" for career mobility that has been recommended. I was glad to hear Dr. Endicott discuss this concept in his speech last night. Everyone seems to be in agreement that there must be developed a means by which college credit, at both the associate degree and baccalaureate level, for independent study, television courses, adult education courses, and other forms of instructional pursuits outside the concept of regular college

curricula can be evaluated and offered credit toward degree programs.

Here in New York State, the College Proficiency Examination Program has mounted a major project, under the supervision of the State Education Department, in an effort to open up the educational opportunities of the State to individuals who have acquired collegel-level knowledge in ways other than through regular classroom attendance.

Why have I emphasized this approach? A logical extension of the credit-by-examination concept must be conceived, developed, and fostered for the allied health professions. This is already being interpreted as one of the major needs if the mobility concept is to be achieved. The relationship of proficiency or equivalency testing procedures as might be applied to the allied health professions is self-evident, though putting it into practice will not be a simple task. If tests can be developed that will establish the common, core elements involved in various health fields, measurement of the level of performance on a test might substitute for the actual taking of some of the now required courses in many fields. Based upon effective measurement devices of such proficiency or equivalency levels, it would not be necessary for an individual to begin at the very lowest level or rung of a ladder in an allied health field, but rather one could be admitted into an educational program or level of clinical functioning based upon his measured capabilities.

Leaders in allied health education must look closely at this emerging concept of proficiency and equivalency testing. They must be a part of the development of plans for implementation of this procedure, for it seems to offer great hope for the community of health programs to examine mobility in careers based upon measurable objectives of instructional and clinical activities.

4. Barriers between and among associations and agencies must be broken down if career mobility is to become a reality for the allied health assistant. Is it not now about time to consider the relationship of each allied health profession to each other — with the starting point of discussion not based upon the relationship of the professions but rather upon the relationship of each to the system of health care and the function of each in relationship to the patient? As we break down the boundaries of indifference and suspicion of intent and concentrate on the similarities which exist in educational programs and in patient care function, we must come up with new ways of working cooperatively together.

5. The relationship between community junior college programs at the associate degree and certificate level with the baccal-

aureate and graduate programs for the allied health professions is one of the most crucial factors involved in the establishment of career mobility concepts. The time has come when those of us in university work must admit in open forum that the solution to some of the manpower problems facing the health community today will, indeed, be met only by the emerging associate degree and certificate programs in the community junior colleges in this nation.

I am certain that there are those junior college educators here in this audience who are saying to themselves, "But the community colleges are not preparing all of our students to transfer to the university programs." This is an objective which must be understood and respected by all of us. But is it not true that the decision regarding educational mobility should not be made by a group of educators, regardless of level, who are concerned about vested interest of their own institutions? What we must strive to do is provide the level and quality of course work which can be adaptable to any level of functioning. The decision of educational mobility should be made by the *student* based upon his motivation, capabilities and vocational goals. There is evidence that such coordination between the community colleges and university programs is beginning to offer rich rewards for student achievement, and I am certain that our discussions the next few days will confirm this assumption.

The concept of career mobility will become a reality only when sufficient time and priority attention is given to deciding what the problems are in each field in attempting to prove or disprove the concept of vertical and horizontal mobility. Who should get involved in this act? It is quite certain that no formula derived by any resources other than the leadership group in the allied health professions themselves, working in collaboration with medicine, dentistry, nursing, and health educators, can bring this about.

Here in our own School, I have seen that the intimate involvement of members of key staff in each department with the Office of Admissions and Records at the University has brought about the kind of transferability that must become standard practice in the future . . . at least for those students who are interested and capable of transfer. For an entering junior class last Fall for just the three departments of Medical Technology, Physical Therapy and Occupational Therapy of 97 juniors, 28 students of this entering class, or 29%, were transfer students from community colleges. In the large majority of these transfers, one hundred percent articulation of course credit was achieved. Close communication between and among the campuses has

brought outstanding students into the mainstream of our own program. I can point with pride to the fact that during the past two years, recipients of many of our awards at graduation have been richly deserved by transfer students. I have no question but that the time will come when such guidelines for articulation will be State-wide in performance. This has been the subject for State-wide meetings, and we can anticipate the day when these "problem" situations of today will be a part of a smoother running educational machine for tomorrow.

SUMMARY

No greater task awaits those of us here at this two day conference than to open wide the doors of communication on the subject of utilization of allied health assistants. We know we have much to share and much to learn from the experiences of the many health professions represented at this meeting. The multi-discipline workshops and panels will have challenges to face that might keep us long after the final whistles are blown for your departure on Friday night.

I have great faith that the leaders in allied health can make progress in this area. But the parochial approach to just one profession must be replaced by a staunch resolve that joint action will benefit all the health professions and the individual health fields as well. The end result will be a comprehensive allied health educational and professional program which will provide for maximum student mobility and choice, with the patient we serve as the ultimate benefactor of our efforts of being allied together.

The final evaluation of our time together here will be the influence each of us can exert in the effective utilization of the allied health assistant in clinical practice.

Goethe's sage advice should be our command:

"Thinking is easy, acting is difficult, and to put one's thoughts into action is the most difficult thing in the world."

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The Assistant's Basic Education

My remarks will be under two general headings, first the Assistant, then his basic education.

The Assistant — to the allied health professional. The professional, at least as the term is used in the health field, generally refers to the members of any group who appropriate the label to themselves. Here at Buffalo, for example, those listed as participating in this conference include Dentistry; Medical Technology; Occupational Therapy; Laboratory Animal Sciences; Community College Teaching; Medicine; Nursing; Pharmacy. There is no need for me to describe to this group the enormity of spread here in the depth and breadth of preparation, to say nothing of the range of responsibility represented. Some of the categories carry great prestige, if only because of their long and illustrious histories as identified specialties, others are relatively new and relatively unknown to the public at large. There are still other specialties, names not included in this Buffalo list, which are still newer and therefore still more unknown to the public. They are coming into a professional existence of their own by a sort of vertical division within a broad area of health care. The members of such a group have succeeded in clarifying their own functions well enough to carve out a fairly neat area of responsibility. This kind of vertical division and definition of health professions has been going on during most of this century parallel to, and as a result of, the scientific development of medicine. A good bit of the division itself has been within that

large and ill-defined area called nursing, but the incentive, it seems to me, has come from scientific developments in the field of medicine. For example, as medicine has become more specialized, corresponding developments have occurred within nursing, which in the old days meant all of the care and treatment given a patient, except that directly administered by the physician. These developments resulted in dietetics breaking off from nursing, as did medical technology, physical therapy and occupational therapy. After they broke off they developed as specialties in their own right.

A newer, and so far a less clear, division has recently occurred on the horizontal plane. It looks to me as though this is seen as most neatly accomplished in dentistry. Neatness however does not appear to characterize this development in other areas. It has gone something like this:

A specialty (vertical division) is declared when some practitioners can define their functions. They set up rigid, often arbitrary, preparation requirements for various reasons; exclude from membership persons who do not meet the requirements; expand their clientele and the demand for their services; and become very proficient in their special skills. Some members come to an understanding of some aspects of their expertise so they can safely teach parts of it to another who is not a certificated member of the clan in order to extend their own special services to more persons.

This kind of development, however, is a highly individualized sort of thing. And now this teaching of the assistant is no longer adequate for two reasons, (1) the time and energy required of the professional who may need several kinds of such assistants, and (2) the assistant himself who, as a member of a mobile society, needs some kind of negotiable credential, so that he need not be retrained if he changes employer.

It is necessary now in 1970 that a health profession clearly define its own area of responsibility and in doing so that two things be determined: (1) which of its functions it has so mastered that they are isolable and can be safely and systematically taught to someone else, someone who will not perform the function out of the same rich background of the professional. If this passing on of mastered functions does not go on, the professional then is not freed to go on to new knowledge and new skills. As a necessary activity becomes routine for a professional who is pressing on to new things, this activity takes on the character of scut work for him. This same activity can take on the character of a new, exciting and satisfying skill to be developed by an assistant.

The second thing the profession must determine is which of its tasks, although closely associated with the peculiarly professional responsibilities, are in fact not demanding of highly educated judgment, so that these tasks may be assigned to someone without the same professional expertise.

When these two things are done — specialized activities sufficiently routinized to be safely taught to others and more general activities identified in order to be delegated, the profession itself can plan formal preparation of an assistant.

This approach to determining the area of responsibility which can be delegated to an assistant appears to me essential in order to develop for the assistant a curriculum with that dynamism which is necessary to avoid built-in obsolescence, which can prepare the assistant to continually take on what are for him new task responsibilities as the professional practitioner moves into new areas of the field.

Basic education of the assistant must encompass that knowledge which is elementary to the field of specialization. Here elementary knowledge will be, and probably should be, taught and learned in a far more technical and mechanistic way than it is for the professional, who should have a more profoundly philosophical grasp of basic principles. (Herein, I believe, lies the major impediment to a straight ladder-approach for health career education.)

The assistant's basic education must include his development of a high degree of skill. Those skills developed out of a solid ground of principles are the only skills the assistant can adapt and develop as changes in health care delivery go on at an accelerating rate.

Such a solid base of principle and theory, technical though the grasp of that base may be, is in large measure taken from the physical, biological and social sciences applied to and interpreted for the health specialty. Here educators must be held accountable. Not only must the assistant be willing to accept and adapt to change, he must be prepared for it. To prepare for change is as difficult as it is important. For this we seek what only general education can provide. Professionals and technicians must be educated persons. To be an educated person is to be wise in a special way. It includes knowing how to evaluate a development in a field and how to change one's behavior by choice to do so.

Another aspect and major part of the basic education of the assistant is the laboratory. I want to focus your attention on this point by considering several kinds of laboratory experience: classroom, simulated, model or demonstration, and clinical.

The classroom laboratory idea is familiar to all. For example, in our physical therapy assistant classroom laboratory there is an elaborate array of special equipment, everything found in a good hospital physical therapy department except the Hubbard tank. The students hear modalities of treatment talked about and see them demonstrated; each manipulates and becomes personally familiar with all of them; each practices and develops skill by use on each other; each, thus, experiences the process of the treatment, excepting, of course, those in which danger attends use of the treatment on the health individual.

There is objection made by some to expenditure of such sums when the same equipment is available in a hospital. In fact, the full range and variety of equipment is available in very few hospital departments. Secondly, this sort of classroom laboratory permits exclusive focus by both teacher and student on the student and his learning. In development of skills, a sound argument for learning can be mustered to support the value of full attention to the student.

The classroom laboratory can be adapted to *simulate* the real life situation. In the Physical Therapy laboratory, for example, a morning is set up very much like the hospital setting with the faculty assuming the role of the staff therapists, scheduling role-playing students for a variety of treatments, and incorporating a large number of the frequently encountered foul-ups of a real life Physical Therapy department.

A *model* laboratory, in my opinion an extremely useful teaching method, is perhaps best illustrated by the one we have for our Child Development program. We at our college operate a day activity center for retarded children. This center, said to be the best staffed such center in our state, both in quality and quantity, selects children who will illustrate the range of retardation, both simple and with a multiplicity of other handicaps, which the Child Development program faculty regards as optimum for teaching. It becomes a sort of demonstration center, although the purpose was, and is, to provide a controlled real-life experience for the college student. The Child Development students also have experience in a wide variety of community agencies for the retarded. What is critically important to education of this assistant in our operation of our own day activity center, is the fact that the entire staff of the center are employees of our college who operate the day activity center for the Child Development Technician student. The day activity center children do not suffer from this focus on the college student need. On the contrary, these retarded children receive superior care and benefit immeasurably from the experience. The effect of its lo-

cation and purpose which bring in faculty and students, is to raise the level of care, and the range of resources available to the retarded child.

This day care center, operated as a model for our assistant level students, gives them prime kinds of experiences. That is, we do not need to schedule them around other perhaps more prestigious folk, like graduate students. This fact is highly motivating to the assistant level student.

The *clinical laboratory*, historically and traditionally the center for preparation of the health worker, of course, continues to have a significant place in health care education and now in preparation of the assistant. Use of the clinical laboratory is changing and, with new understanding, I hope will continue to change. It must become a much more selectively utilized experience for several reasons: (1) the increasing number of students creates a standing-room-only situation which saturates the patient and dilutes the learning value of the experience for the student. Furthermore, the complexity of this real-life situation tends to introduce so many intense stimuli at once that the student's attention and energy are dispersed in a variety of directions at once. For this latter single reason it appears to be greatly to his advantage if he has mastered as many skills and learnings as possible in the more protected classroom and laboratory setting. There is extremely important learning to be done in the clinical area, but the teacher and student must be very clear about the purpose of each laboratory period, preferably including a preparatory conference in the clinical setting itself, anticipating as much as possible the complications and obstacles likely to arise to interfere with the student's intended plan of action. As urgently needed also, is a retrospective conference immediately following the experience in order to crystalize the passing experiences into learning. Verbalizing of experience focuses the student's attention on something which otherwise might soon be forgotten. It requires the student to consider alternative ways in which he might have responded in the situation he has just experienced. Without careful and extended planning the clinical laboratory experience is in serious danger of becoming a mere work experience in which the assistant level person, who by virtue of being at this level, is not equipped to select and capitalize on the multitude of learning possibilities in the work situation — he has to be taught how to do so.

With careful planning and help — largely through discussion and mutual consideration of a point — the clinical laboratory experience can become an unexcelled learning experience.

A matter of major concern in preparation of all levels of

health workers is that of evaluation of competence. Assessment of performance in the clinical situation is of particular importance for the assistant. This level student, who has a truly respectable fund of knowledge, does not have the depth and breadth of theoretical background which we presume in those with four, six, ten or more years of study. The need is for adequate and precise evaluation of performance in the clinical setting. Development of methods and evaluators is an urgent matter, and as far as I can tell this has not yet been achieved in any health field. Time blocks of clinical experience and ratings by staff people may have a purpose but I don't know what it is. They assuredly are no substitute for faculty assessment by reliable measurement of student performance in relation to sharply defined objectives.

This newly devised level — the assistant who has had a basic education preparing him for the position, will assuredly encounter the problem of any newly emerged species, ranging from outright rejection to enthusiastic embrace because he is erroneously perceived as the answer to all manpower problems, which he is not, although he surely can be a sort of boon. Those who reject him do so because they do not know what he is, or because they do know what he is and see him as a threat. (In my opinion an enormous number of people who loudly proclaim their professional status, its privileges and responsibilities, in fact, operate consistently on the technical or assistant level and in fact ought to be threatened.) At present, rejection is most often seen in the fields most newly identified as professional and therefore where the assistant is newest.

We need much discussion and education to understand the really significant potential of the assistant, and we need to share the wealth of this knowledge and understanding with the public as well as with other health workers.

We need to prepare the fledgling assistant to expect rejection as well as ill-conceived over-acceptance by telling him of and helping him to have at his disposal, some constructive ways of dealing with the problem often manifested in a variety of ways.

Miss Verle Waters one time told us of a device she uses to prepare the Associate Degree Nurse for being thrown to the lions of the more traditional system. Just before graduation she sets up a series of sessions on anticipating problems in which a variety of miserable, frequently met with, situations are role played. Then through discussion the student comes to understand some of the forces at work in the system and is prepared to deal constructively and honestly with them. He builds up a repertoire of constructive solutions on which he can call during times of stress.

The recognition of problems, the calling of conferences, the gathering of people like us, means the emergence of the well prepared health professions assistant is well along, and I love the sight of it.



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The Need: Who? When? Where?

The winds of change are stirring, moving more at a rate of gentle breezes than in brisk gusts at the present. Before we talk about the particular subject of this conversation, the use of assistants to the allied health professional in the delivery of health care, it may be helpful to place the subject, however sketchily, in its historical perspective. The assistant to the allied health professional is a relatively new phenomenon, in terms of what has occurred on the health manpower scene in the past two decades. We all know that nursing led the way with the development of the nursing aide or nursing assistant; and, to my knowledge, among the allied health professions, the occupational therapists were among the first to identify an assistant through their Certified Occupational Therapy Assistant Program. Not only the use of assistants, but the entire development and growth of the allied health professions are very much phenomena of the 1950's and 1960's. You are well acquainted with what I refer to, for in that period of time we have come to look upon the dental technician, the inhalation therapist, radiologic technologist and the

laboratory technologist, among others, as talents to be expected on the contemporary scene.

As you well know, all of this change — new kinds of health manpower — came about because of the growth in our national economy, which has permitted an increasing proportion of goods and services resulting from this higher rate of national productivity to be devoted to research and development in health care as well as the increased purchase of health care services. With the advent of Medicare and Medicaid in the mid-1960's, we had an increased demand placed upon existing health care resources — not only facilities, but manpower resources. With this demand came — to this country — the concept of health care as a right rather than a privilege. This philosophy is the stimulus causing an increasing number of people to explore and forge for more efficient ways of using manpower and other health service resources.

Even with our questionable practice of importing foreign physicians to meet our health manpower requirements, it has been readily apparent that we cannot meet our manpower needs by relying on traditional definitions of job functions for various personnel. To my knowledge, the pediatricians were among the first as an organized body of physicians to recognize this. Their identification of several pediatric assistants is a credit to the American Academy of Pediatrics and the innovative pediatricians who are methodically defining those functions within pediatric practice which require the knowledge and talent of the pediatrician and those which can be delegated, with sound results, to individuals requiring less preparation. Reportedly, approximately 80 percent of the pediatrician's normal practice can be appropriately handled by other than the pediatrician, as long as he is handy for consultation. Obstetricians in this country are facing the same phenomenon, in that there will not be an adequate number of physicians choosing the specialty of Obstetrics to safely provide for the prenatal, delivery and postnatal care of the young women who will become mothers during the present decade. This situation is causing serious consideration of how we shall use the midwife in this country.

There is a similar exploration in identifying more meaningful ways of providing the traditional health care services provided by a family physician. Primary here is the exploration in the use of the physician's assistant, as perceived by the program at Duke University and Medex Program at the University of Washington and others. In my judgment, it is significant that Doctor Bornemeier, current president of the American Medical Association, announced early this year that the body politic

of medicine recognizes that some of the functions "relating to treatment could be safely delegated to paramedical personnel and especially nursing."

One of the more recent basic reference documents relating to health manpower is the 1967 report of the National Advisory Commission on Health Manpower, which was created by President Johnson. Chairman of this Commission was Doctor Edward Forgotson. The members recognized that not only would the country have to reduce its dependence on foreign-trained physicians and invest heavily in increasing the number of medical students already in schools, but that the shortages were as much a product of the manner in which we organize our programs for delivery of health care as anything else. The report stated:

"There is a crisis in American health care. The intuition of the average citizen has foundation in fact. He senses the contradiction of increasing employment of health manpower and decreasing personal attention to patients. **The crisis, however, is not simply one of number.** It is true that substantially increased numbers of health manpower will be needed over time. But if additional personnel are employed in the present manner and within the present patterns and 'systems' of care, they will not avert, or even perhaps alleviate, the crisis. **Unless we improve the system** through which health care is provided, care will continue to become less satisfactory even though there are massive increases in cost and in number of health personnel."

As new mechanisms for delivery of health services are created, or the current ones modified, the allied health professional and his contemporaries will have to reexamine job functions which fall within the purview of their discipline.

DETERMINANTS AND MEASURES OF NEED

I have been asked to talk with you about the need for assistants to the allied health professions. At the present time I have no question that there are needs. But I know that they have not been adequately quantified, primarily because the needs are in process of searching for a definition.

When we look at the matter of creating assistants for the allied health professional, there appears to be great risk that each profession will want to create its own cadre of supporting personnel. This may be necessary, but let us first make certain — that is, if we are indeed committed to providing better health care for all the people — at a cost each one of us can afford.

First, look at the settings in which these people are to function — the nursing home, extended care facility, inpatient or outpatient service of a hospital, a home care agency, or what have you. These institutions and agencies are found in rural and

¹National Advisory Commission on Health Manpower, REPORT, Vol. I, P. 2.

inner-city settings as well as suburban. It is not likely that the matter of maldistribution of manpower found among these settings will be resolved for some time.

How do you go about determining what is needed; what measures are available? Two traditional patterns for identifying need in the health services have been the use of (1) professional standards and (2) personnel-to-population ratios. An example of the professional standards approach to estimated needs for manpower was the Lee-Jones Study in the early 1930's. It is this method in which one first determines the frequency with which illness occurs in the nation's population; then gathers a consensus among experts about the number of services required to treat or diagnose a given illness; then estimates the number of services which a provider can handle in an hour; and lastly obtains an agreement on the average number of hours that an individual provider would spend during a year in caring for the patient. Such a process is very complex and open to all kinds of opportunity for disagreement. As a result, the Lee-Jones Study has not been replicated.

The use of personnel-to-population ratios leaves much to be desired also, for things change — the functions of people, their productivity, changes in ways in which services are organized, and the like. One of the reasons this method is most frequently used is that it is relatively simple. It is based on the assumption that present staffing is adequate and that future changes in demand for services will be offset by changes in supply of manpower to produce them. Economists have a few other sophisticated methods by which to identify need. Klarman reports that interestingly, the professional standards approach usually results in calling for a larger number of professional personnel.

The Report of the National Advisory Commission on Health Manpower identified what it considered to be a sad lack of adequate data:

"Our conclusions and recommendations are necessarily qualified because of our inability to obtain truly adequate data on the medical care system . . . There is a serious lack of the consistent and comprehensive statistical information that is required for rational analysis and planning, despite a surfeit of numbers about health. In our recommendation, therefore, we have tried not to go beyond what seems reasonably supported by the available figures, confirmed by our collective judgment. A more detailed and specific report would have resulted from better information."

The critical message here is to develop all the data you can, but to recognize that much may remain without definition and will have to be satisfied by the qualities of your judgments in

Klarman, Herbert E., "Economic Aspects of Projecting Requirements for Health Manpower," *The Journal of Human Resources*, Vol. IV, No. 3, P. 362.

what to do about creating or modifying assistant categories or proceeding in professional splendor without the need for assistants.

Doctor Eleanor Gilpatrick, an economist in the Health Services Mobility Study at City University of New York, has developed a methodology for identifying job requirements and matching these with various levels of educational preparation. In many respects this appears to hold great promise in identifying the validity of the need for creation of an assistant for a professional discipline. The methodology provides for an analysis of the individual tasks within a job, according to levels of knowledge and levels of skill required. Dependent upon how these knowledges and skills are related in groups, given jobs can be modified either by amplification or by job enlargement, or a significant advance in job function, all of which imply a critical need for an educational system which is responsive to the preparation of personnel for changing job requirements.

MODELS FOR USE OF ALLIED HEALTH PROFESSIONAL ASSISTANTS

In my mind, the most creative models for the use of allied health professions assistants existing in the contemporary American scene are found in the military services, and we should look carefully at what they have done and are doing. The military has never had to be concerned with the strictures imposed by state licensure laws and national certification or accreditation programs. Nor have the Veteran's Administration Hospitals. Yet, prior to 1968 there was no serious experimentation in the use of allied health manpower in the VA System. The comprehensive prepaid health programs of the Kaiser Foundation Health Centers are commonly referred to as models of economy for the delivery of health care, and justly so. Nevertheless, within these health centers there have been no notable departures from the traditional patterns of using health manpower resources.¹

Apparently, we may not have a great deal to learn from other nations either. Doctors Edward and Judith Forgotson, in their study of experiments in the uses of health manpower in the United Kingdom and the Soviet Union, found a lack of interest in manpower innovation. Granted, their primary focus was on the study of midwifery and coronary care in the United Kingdom

¹Gilpatrick, Eleanor, "Technical Support for Building Job and Educational Ladders," a presentation to the National Manpower Policy Task Force Conference on Upgrading and New Careers, March 20, 1970 (Unpublished).

²Robbins, Anthony, "Allied Health Manpower," *Inquiry*, Vol. VII, No. 1, March, 1970, p. 58.

and the use of feldshers in the Soviet Union. But most of the care provided in coronary care units in the United Kingdom is given by physicians, and if sufficient physician manpower resources are not available, the hospital simply does not provide for an intensive coronary care program. In both countries it was reported that:

"They are not actively pursuing research either to keep these workers in dynamic roles or give them new roles in the delivery of medical care. Neither country studied offered any experience in experimental uses of manpower to solve current or evolving problems, and in neither country was there any mention of manpower research to define or redefine appropriate tasks for various manpower members of those categories."³

We are finding interesting innovations arising out of OEO-Funded Neighborhood Health Centers with the advent of the community health aide as an assistant to the public health nurse, as well as an expanded body of responsibilities for the public health nurse.

In many respects our shortages in health manpower give us the opportunity to develop much more productive and economic means of providing a high quality of health care at a lower unit cost. I was impressed with Doctor Anthony Robbins' discussion of how inflexible we currently are in our use of health manpower resources. He stated:

"It is easy to find examples where the whole composition of the work force producing a service can be changed radically and still produce the same service. Doctors in hospital out-patient clinic practice can double the number of patients seen simply by shifting some tasks to the nurse. Patients whose return visit is for a very well-defined purpose need not see a doctor at all . . . I think we could go one step further and let the nurses see all the patients all the time, using physicians only as consultants."⁴

Reportedly, the latter practice is occurring in some of the clinics in our major teaching hospitals in which the nurse does see all the patients and the physician is used as a consultant. Fortunately, teaching centers have the status and an adequate system of internal checks and balances to assure us that such explorations are indeed safe. We can only hope that their innovative findings will not be too long in moving out of the teaching center for adaptation to other settings for patient care.

In examining the need for assistants to allied health professions, the primary question is "is this trip really necessary?" Where or in what type of settings will the assistant work, in the hospital inpatient or outpatient services, the nursing home, ex-

³Forgotson, Edward and Judith Forgetson, "Study of Selected Innovations and Experiments in the Uses of Health Manpower in the United Kingdom and the Soviet Union," *Medical Care*, Vol. 8, No. 1, January-February 1970, p. 13.

⁴Robbins, *op. cit.*, p. 56.

tended care facility, home health agency, public health department, or neighborhood health center? To what extent is it technically possible to substitute the assistant for the professional? The economist says we can justify the substitution when it results in a lower cost for a given output (and with no reduction in quality); but there are other significant considerations as well. First, to what extent can a profession provide an adequate cadre of competent personnel to supervise the assistants? Second, when the demand for services is randomly variable there may be greater efficiency in using personnel with broader training to perform two or more functions. In other words, the assistant may be better used when demand for technical assistance is relatively constant and of sufficient volume to justify the assistant's existence. Third, how content will the assistant be to continue working as an assistant? That is, what will we offer him that is attractive to his remaining in that capacity? What opportunities will he have for job advancement? Will we make it possible for him to have reasonable access to joining the ranks of allied health professionals?

Fourth, if we would create an assistant, to what extent is it feasible to prepare him to serve more than one discipline? That is, in what kind of settings would you expect to find most of them working? For example, is there any particular reason why a physical therapy assistant could not also be prepared to function as an occupational therapy assistant and a nursing assistant, bringing a broader range of talents to the rehabilitation service, whether hospital inpatient, nursing home, or home health agency? Is there any particular reason why an inhalation therapy technician cannot also be prepared to function as an EKG technician and a nursing assistant for similar reasons?

It is hoped that the allied health profession would involve others in the decision processes required to determine if assistants are desired. Among the others are related professionals with clinical orientations including the physician, representatives of institutional and agency administrations in which the professional functions, the manpower economist, operations researcher, and possibly, as they become more plentiful, the ombudsman or patient advocate. Such a variety of perspectives may contribute to decisions that may better stand the tests of time.

No doubt we should expect pockets of innovation. I hope we can tolerate a greater diversity so that supporting personnel can be created to meet the particular requirements of given health care delivery settings.

¹Klarman, *op. cit.*, p. 361.



ELLIOTT E. LEUALLEN

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Certification and Licensure: Blessing or Boondoggle?

The title of this paper raises a question for which there will be diametrically opposed answers under particular conditions. Hopefully we will find ourselves describing a few attitudes and objectives against which the question might be answered in a specific case. As a matter of fact this is the only sound basis on which to answer the question since certification or licensure is defensible only when a number of conditions are met. Even under the best of circumstances there are some effects that may not be wholly to the liking of the licensee, and others that may not always be completely in the best interest of the public.

I shall start with the assumption that we have clearly defined for the assistant a role to be performed. Without exception this task must be completed as the first step toward any thought of certification or licensure. Whether we are dealing with a dentist's assistant, a pharmacist's assistant, a physician's assistant, or any other assistant to a professional person, there must be a clear understanding of his duties. I also assume that the term "assistant" is deliberately chosen. We are not dealing with an independent practitioner even though a great deal of the assistant's activity may be carried out without immediate supervision. In the main, however, all of this unsupervised activity could legally be performed by anyone whether or not he had qualified as an assistant, by whatever standards are imposed.

The assistant that I am talking about, therefore, is a person trained to do a part of the skilled work of the professional whom he assists. He moves into the area of practice otherwise restricted to the professional, but he moves only so far as the definition of his role permits and his work is subject to the supervision of the professional.

The definition of a role makes possible the determination of a training program. And here we face, for what I hope will be only a few years, a serious contradiction. Training programs are indeed already underway prior to a clear understanding of their purpose and with only limited avenues of employment for the product. Great care must be exercised to avoid the raising of false hopes for unreachable goals. To realize some of the objectives in the utilization of assistants changes will have to be made in the law.

Of course, if I am wrong in my definition of the assistant as a person trained to take over some measure of the duties of the professional, then my concern over his full employability is unfounded. In such a circumstance there would be no point in even discussing licensure or certification.

So let us return to the assumption that we are dealing with an individual who has completed an organized program of study and training to fit himself for a role of providing assistance of defined scope. Should he be subject to certification? To licensure? To neither?

Should he be subject to certification? Yes, if there is to be affirmation of his having gained a stated minimum level of competence in a definite but usually broad subject area, if would-be employers are to be assured of certain standards having been met, if there is to be reasonably simple lateral mobility from job to job, if the work to be performed requires a significant level of technical skill and judgment, and if others may be expected to carry out almost the same duties without the benefit of certification.

Certification is a protection for the public or the employer. The person certified has met the standards imposed by a certifying agency, whether a peer group such as a professional society or a governmental body such as a state board. It does not confer any exclusive right to a field of practice except in conjunction with the use of the title.

This "non-exclusiveness" is a fundamental characteristic of certification.

Now let us ask "Should the assistant be licensed?"

The answer is "yes", if there is to be evidence of at least a

minimum level of proficiency, if there is to be lateral mobility, if skill and judgment are required, and if, in distinction from certification, there is a clearly defined and circumscribed field of service that becomes the exclusive domain of the licensee except for such functions as may be permissible also for holders of licenses in other fields.

Here, then, is the basic difference between certification and licensure. The one attests to a qualification, the other does this and, in addition, grants an exclusive right.

Having said this, I must now admit that the distinction is not always so clear-cut in practice. If, for example, a certification for a particular profession is created in, say, the Education Law, then, in another part of state law a requirement is made that only a person so certified is authorized to perform a particular function, the net result is an exclusiveness akin to licensure.

The last of the three questions asked a few minutes ago was, "Should there be neither certification nor licensure of the assistant to the health professional?" Here the answer can be "yes" only if some combination of the following two circumstances exist:

- 1) **either** the assistant does nothing that comes within the scope of the professional practice **or** authorization is provided in the law for the assignment of duties according to the judgment of the professional and with full responsibility and liability remaining in the professional, and
- 2) the professional trains his own assistant to do just what he wants him to do or he knows what particular preparation he has received elsewhere, either during employment or in a training setting.

In my opinion, there should be and will be certification by the state of a number of health professions assistants. It is possible that there may be licensure but evidence sustaining the need or desirability of this has not come to my attention.

A discussion of the certification of health professions assistants is not complete without a reminder that the state will impose such a requirement only in the interest of the public. Although many benefits may accrue to the individual who is able to have this stamp of approval, it is not for this purpose that certification exists.

The individual who has achieved certification or licensure has an accountability that he did not have before. His acts are subject to review by his peers and the statutes spell out specific penalties for various actions judged to be not in the best interest of the public.

In answer to the titular question I would say that there are areas of health services where certification of assistants will be

beneficial, if not quite a blessing, and there are areas where certification would be a trivial and wasteful exercise representing only an adornment.

If there is danger in the concept of certification of health professions assistants, it lies in the possibility of a rigidity of standards and a singularity of approach that would be as restrictive of the certificants as it would be prohibitive to others.

Without any implied judgement of the policies of the past, it can be stated flatly that we face today the positive necessity of evolving various routes and means by which an individual can achieve the level of competence deserving of certification.

I do not suggest that the classic approach be abandoned. A program thoughtfully and purposefully planned to draw on both academic and clinical experience is the most direct and economical way to reach a goal of preparedness. It is not the only way however and a serious weakness in our present system of education for the professions is that it fails to provide alternate routes.

More difficult than developing alternate routes to certification is the task of avoiding dead-ends which prevent the realization of one's full potential and deprive society of the benefit of more sophisticated service. Difficult, but well worth the effort required.

In conferences such as this one, there is the most likelihood of resolving these troublesome issues. I am optimistic about the outcome as there is deep commitment on the part of health personnel, educators and government to achieve a pattern of service which brings benefit to both man and society.

In these remarks I have spoken in favor of a meaningful certification for certain health professions assistants. I believe there must be more than one level of entry into multiple preparatory routes and that career ladders must be available for those who have the ability to move forward.

As a representative of the State agency having principal responsibility for the education, licensing and supervision of the professional conduct of health personnel, I can speak with assurance of our intention to move with the times and to support constructive changes.

Multidiscipline Workshop 1A

RUTH ROBINSON, OTR, *Chairman*

KATHRYN SAWNER, LPT, B.S., *Recorder*

RONALD SEYMOUR, *Senior Student in Physical Therapy, Coor.*

A central theme around which discussion revolved in this multidiscipline workshop group can be stated as follows: that any design for utilization of assistants requires that institutions first design a method of recognizing employee ability, whether that employee is trained on the job or in the formal academic sphere, and that more realistic steps be taken to facilitate upward mobility than are perhaps presently being taken.

The discussants believe that there is a definite lack of sound foundations upon which to build mobility channels at all levels of personnel (aid, assistant, etc.) in all allied health professions. Participants expressed the thought that, prior to the establishment of effective upward mobility programs of a formalized, institutional nature, there must be a means for recognition of individual ability. It was apparent that most facilities lack a merit system, perhaps because of the lack of a sound, objective means of so doing. Rather, they provide monetary reward for length — not quality — of service to the institution. Pre-requisite to development of objective "mobility via ability" is role definition, a present lack in most organizational structures. It was suggested that since quality of service to the patient should be the objective of all endeavors, we may not necessarily need more assistants but rather better assistance and quality care with the personnel now available. On the job training with recognition for ability would be a vehicle toward attainment of this objective.

In conjunction with the above, there appears to be no vehicle available to credit knowledge gained from experience only. Hence, it is difficult, if not impossible, for the individual to advance in stature within the facility nor to advance by moving from one facility to another. The latter is rarely possible even if in-service education is available, since inter-hospital reciprocity for in-service education is non-existent. In summary, then, there is an apparent lack of foundation upon which to build steps for upward mobility based on ability. If the general tone of this group's discussion is indicative, this is one of the basic problems in providing security and motivation for semi and/or non-professional personnel and one requiring immediate remedial measures before effectiveness of utilization of assistants will be possible. Role definitions of personnel at all levels must be the cornerstone of this building process.

A most provocative thought emerged to the effect that although academic education appears to be the immediate step being taken to provide upward mobility, it is, in its present form, not necessarily the most practical, advantageous, nor realistic "mobilizer." The foregoing considerations support this hypothesis. Further, in attempting to elevate their own statures (both educational and socio-economic), persons trained on the job, when entering an academic setting (i.e. Associate degree program) may face the following problems: 1) The realization that they do not satisfy all prerequisites for the curriculum and that there is no available means in either the clinical setting or the academic setting to satisfy these prerequisites without having to spend additional semesters in the academic setting; 2) that they must "take," for academic credit, course material with which they are already familiar, resulting in negative expenditure of time, energy, and money; and 3) upon completion of the program, finding that there may not be positions available commensurate with the new level of education (i.e. in the New York State Department of Health system, there is no "line" for certified occupational therapy assistants; this line does exist in the Department of Mental Hygiene). Hence, the following questions were considered: (1) How can the potential student prepare for the academic setting? — and (2) How can the academic setting prepare for the student? That answering of these questions is the mutual responsibility of both the educational institution and the licensing or certifying body (i.e. professional organization) was looked upon as being the only realistic approach toward solution; guidelines for curriculum planning and development must be a joint effort. Inherent in this process is the initial necessity for evaluating and applying appropriate credit to knowledge and/or skills gained on the job. Succinctly, equivalency examinations must be developed. Several of the participants cited examples whereby academic credit by examination is being given for previous practical work performed by the student.

Dr. Leuallen was called in and asked to give his thoughts on equivalency examinations. Recognizing the magnitude of the tasks involved in the development of equivalency examinations, he did suggest that such devices are the root to the problem of qualifying for entrance into associate degree programs. Examinations must be made available which can be evaluated in terms of the individual's strengths, weaknesses, and "gaps" (areas with which the candidate is unfamiliar, but which are pre-requisite to entrance into the particular degree program.) Equivalency examinations were seen by discussants not only as a mechanism for determining eligibility for entrance into degree programs, but also as the only objective means for evaluating merit for intra- and inter-

facility advancement.

That the equivalency examination is not the entire answer toward upward mobility, is seen by the previously mentioned "gap". It was apparent from group discussion that few and limiting channels are open to the potential student whose previous training presents "gaps" or deficiencies toward entrance into the academic curriculum. It is this step in the mobility ladder that is perhaps the most important one, but also the one to which the least attention has been directed. As suggested by Dr. Leuallen, libraries of programmed learning should be developed and made available as a means of "filling the gaps" toward qualification for entrance into the academic curriculum. Dr. Leuallen questioned whether or not this has been tried and could it not also be used to up-grade aides who cannot go on to school? Following the program, a standardized examination would permit an objective means for providing recognition for achievement. It was mentioned in conjunction with this that steps must be taken toward educating the consumer to the merit of on-the-job trained persons.

Returning to the "gaps mechanism," participants believe that this should occur in on-job settings whereby the individual would ultimately be able to proceed easily to the academic institution without losing credit for work done on the job. It would therefore appear that the "gaps mechanism" must be a joint effort on both clinical and academic levels to provide immediate fulfillment (i.e. no other prerequisites for admission to the program) of the student's individual needs. Presently, the New York State Department of Mental Hygiene provides hospital-based in-service education programs followed by examination and resultant upward mobility. Ultimately the student becomes able (via in-service education and examination) to enter the educational institution. Programs, examinations, and qualifications for advancement are standardized, thus also providing for inter-facility mobility.

Finally, providing multiple methods for taking the same academic course was discussed as a means of reaching more people. For example, in one instance students are able to take the same course in three different ways: correspondence (the student must be hospital-based simultaneously), night school, or full-time. Could standardized in-service programs also be an alternative? Although having bearing on equivalency, different types of educational programs all leading to the same level of recognition (i.e. occupational therapy and dietitian assistants) were identified as a problem of employer education, not of the academic or licensing (certifying) process.

In summary, it appeared to our group that 1) foundations must

be laid for "mobility by ability" whether achieved on the job or within an educational institution; 2) role definition must be the cornerstone of these foundations; 3) standardized equivalency examinations are basic to objective upward mobility; 4) a "gaps mechanism" must be established to facilitate upward mobility.

Multidiscipline Workshop 1B

KAREN KARNI, MT (ASCP), M.Ed., *Chairman*

RUTH SMILEY, OTR, M.A., *Recorder*

ANGELA FRICANO, *Junior Student in Occupational Therapy, Coor.*

The group took up the question of accreditation zeroing in on the confusion, particularly for community colleges, attendant with the situations of multi-accreditation agencies. The community colleges seeking to establish curricula for allied health assistants found these to be major roadblocks to facile establishment of programs to meet manpower needs. Medical Technology was singled out as an example of the impasse and the President of the American Society of Medical Technologists, Roma Brown, reported that steps are being taken to have but one accrediting agency. The group recommended that others follow suit and thus eliminate at least one of the problem areas in setting up new programs.

The subject of nursing home needs for allied health personnel opened up related areas of level, supervision, status and justification for the assistant. The group expressed the view that nursing home administrators might well use the consulting services of qualified allied health professionals in the planning-to-hire phase and that out of these interactions a clearer picture of "who?, when?, and where?", might emerge. Such questions as level, number and specific specialities could be resolved and a realistic document of need might well emerge. The real gains however, would be in improved patient care and reduced costs.

The articulation of community college graduates into full four-year professional sequences was aired with a strong feeling that non-traditional approaches in admissions policies ought to be explored. Considerable time was spent on examining the impedences set up by standard operating admissions procedures (SOAP) and a firm realization evolved that Dr. Perry's hopes for greater mobility might well be impeded at this most critical entry, or re-entry, point on the ladder or lattice. In this same

area of discussion, the critical differences between technical and professional educational programs were brought to the fore. The two primary curricular differences noted were depth in the discipline and breadth in the humanities, social studies, arts, etc., believed to be necessary to functioning at a conceptual level. Dr. Husted, Conference Chairman, suggested that a modified, even individually tailored, upper division program might be devised to provide the disciplinary depth and the academic broadening not found in the associate degree programs. Since the "basics" of arts and humanities are part of some community college curricula, the upper division curriculum needs only to build on these and, at the same time, add depth to the professional discipline. The problem, in part, suggested Dr. Husted, is "hardening of the categories" at all academic levels and that sincere dialogue and information exchange "in academia" would do much to improve articulation and mobility.

The discussion of utilization of the assistant and of the curricula needs led naturally to the responsibilities of the baccalaureate professional in the area of supervision and administration. To this end, the group recognized the critical need for courses in supervisory/administrative principles and techniques on the baccalaureate level as well as learning experiences designed to provide the student with an understanding of role relationships among all students in the health sciences. Additionally, the baccalaureate curriculum should include orientation to the disciplines of education since most health educators arrive at the teaching role quite by reason of "being there" and, thereby, are expected to instruct assistants, students and others.

The group concerned itself with the problems of continuing education for all levels of health professionals recommending that all agencies should provide their staff with time and opportunities to continue growth in their professions. Noted for its contribution to the resolution of these needs was the telelecture network of the Regional Medical Program of Western New York.

The discussion of Regional Medical Programs and its attempts to involve large geographical areas led into the problems of staff recruitment in rural areas. Students in the group suggested that "... young, single women go where the young, single men are. . . and they are usually in the cities; salary is another major factor." Quality or job attractiveness were not seen as important as the opportunity to satisfy personal needs. Additionally, as a student in medical technology pointed out, those who work in the more rural areas are asked to perform many duties outside his/her area of specialization. Perhaps, then, there

is a need for a multi-discipline person with greater knowledge of allied health areas.

There seemed to be a swing back to the community college issues and representatives in the group from community colleges challenged the guidelines established by some professions — they felt that some of the course requirements were unrealistic. For example, they objected to the continuing emphasis on the number of hours in a subject rather than quality of content. The group seemed to agree that dialogue and compromise are needed in this area.

Unresolved questions were:

How much can the health professions give on a baccalaureate level to heighten perception about the change process?

Should professionals be agents of change?

How do professionals respond to changing roles and changing demands and, in fact, accelerate change?

Is a person with a baccalaureate degree considered a professional?

Multidiscipline Workshop 1C

BARBARA COSSOY, RPT, M.A., *Chairman*

MARY ELLIOTT, OTR, M.S., *Recorder*

GEORGE MASI, *Graduate Student in Occupational Therapy, Coor.*

Group 1C found seven major areas of concern arising out of the five major papers and out of the expansion of the issues raised in process. These were: 1) A need for a clear definition of responsibilities of manpower at all levels; 2) a consideration of opportunities to all personnel for upward and lateral mobility; 3) the advantages of "core curriculum in basic courses; 4) the need for cooperation in coordinating training between junior and senior colleges; 5) the experiences of certification and licensure and the qualifications of assistants; 6) shortages at all supervisory health professional levels; 7) the utilization of medical corpsmen and of high school dropouts in health care.

1) The first issue brought the group to a feeling that professions can recommend guidelines describing the responsibilities appropriate for employees with varying levels of experiential and/or academic preparation. Implicit in this assertion is the request that health care administrators use the fully qualified

professional as a consultant in establishing guidelines and typical task descriptions at each level. There was the fear that, too frequently, those who administer a "facility" delegate according to that which the employer finds acceptable, and these levels of acceptability do not always coincide with employee competence or prior training. The need to clarify job descriptions without losing flexibility within the professions was seen as of greater priority than developing job descriptions which encompass more than one professional discipline. Within this, there was evidenced a need for increased communication between the professions in respect to education, function and role relationships.

2) Dr. Perry's comments on mobility gave rise to a discussion of mobility outside of that provided by academic advancement and it was the group's opinion that incentive for financial and other advancement might well arise out of better recognition of satisfactory or superior service. The value of in-service education and other growth opportunities should be extended to increase knowledge and to provide means of advancement, particularly to give aides the opportunity to qualify for certification. Reference was made to the "grandfather clause" to the end that provision must be made for aides to qualify as certified assistants. Other avenues and evaluative mechanisms such as proficiency and equivalency examinations were recommended.

3) The group recognized that any discussion of education of assistants or baccalaureate students must include a consideration of "core" curricula and/or multidisciplinary basic courses. The basic sciences of chemistry, physics, and math; the social sciences of psychology, sociology and education and the health related sequences of, particularly, the anatomies were considered as ideally amenable to core teaching. The major problems appeared to be people oriented rather than subject oriented and that coordination of these might be considered by academicians with close consultation from practicing health professionals.

4) Concern for the coordination of associate degree and baccalaureate programs gave rise to the realities of the demotivating, impeding effects of "credit loss" in the transfer process. The needs for manpower would seem to mandate a greater need for increased communication leading to greater ease of articulation and mobility with minimal loss of credit. Each must adopt an attitude of respect and a desire to better understand the similarities and differences in the various academic and professional programs.

5) Certification and licensure, so adequately covered by Dr. Leuallen, was discussed from the vantage point of the historical perspective of the professions of physical therapy and occupa-

tional therapy. Physical therapy has had a successful experience with State licensure having worked hard to develop the baselines. A major problem, however, is found in the fact of State control and considerable effort is now being expended in developing state-to-state reciprocity. Occupational therapy, on the other hand, has a National registration with minimal State control. While this, too, has its unique problems, it was considered to be quite advantageous in this age of professional mobility. The discussants returned to other aspects of the question of job or task definitions introduced at the beginning of the workshop. Again the subject of the employer's delegation of responsibility to personnel became the focal point. The group concurred in the notion that it is more difficult to control responsibility given to personnel in a facility. Further, it was recognized that capabilities of aides and assistants vary widely as does his/her capacity to accept responsibility and that these personal variations are compounded with the variables of the needs of the employing facility and the professional environment. Other salient factors include the variability in the amount of supervision needed and the disparity between the expectations of the assistant that he/she will be supervised by a professional person of like discipline and the ability and willingness of the administrator to employ such professionals. A further complication was posed in the realization that the responsibilities a certified assistant should be prepared to assume are frequently assigned to an aide who is less qualified and usually less prepared to carry them out. All of this leads to the need for a more universal delineation of tasks at each level and for each discipline.

6) Personnel shortages are felt on every level and this group saw the shortage of professionals to supervise aides and assistants to be of critical dimensions. Further, the teaching responsibilities are also affected by these shortages to where aides and assistants should be considered able to teach "skills" courses and to supervise clinical experience of students in assistants programs (to some degree). There were some in the group who posed the thought that since assistants programs drew so heavily on professionals time for instructional purposes, that some geographical, numerical limitations might be considered. Further, many who finish two years, who *might* have gone on for four years, become "satisfied" and stop short of the full professional degree. No data were cited to support this nor to give the group a feel for the magnitude of this drain.

7) The discussion of the need to press a variety of "neglected" persons into health service ranged all the way from high school dropouts to medical corpsmen. The group noted

that several community agencies and services were taking an active interest in the high school dropouts to interest them in participating in health assistants programs. A more promising group with related specialized skills were the corpsmen and the participants agreed that greater coordination should exist between the military educational programs and the civilian health assistant needs.

Multidiscipline Workshop 1D

F. ROBERT OWENS, M.S., *Chairman*

ELIZABETH J. PATTERSON, B.S., *Recorder*

JOSEPH AZBELL, *Senior Student in Physical Therapy, Coor.*

During this workshop, the general discussion centered around the educational hierarchy and the changes necessary within the present system to realize career mobility.

On the community college level, one of the problems in initiating new programs is obtaining financial support. A method to counteract this problem would be to first poll the needs of the area and design a program to meet those needs. If it can be demonstrated to the hospitals and institutions in the area that their facility would still be supplied with skilled staff, yet they would be relieved of the financial burden of on the job or academic training (i.e. diploma schools of nursing,) these facilities can then lend some financial support to the program. Another avenue would be to use developmental funding to initiate the program, and, once successful, more established areas of institutional funding could be sought. It was also felt that this type of academic program could be proven to be the most efficient and economic means for meeting the manpower needs.

In regard to the overall crisis in health care needs, it was generally agreed upon that unilateral efforts are insufficient in realizing an overall program of career mobility. A cooperative system between all allied health personnel is, of course, the method of choice. At the present time, a major block to this cooperation is the fact that the established educational programs are separatist in nature. Rather than further specifying our differences, we should identify our common bodies of knowledge and formulate a core curriculum. With this core, specific skill training could take less than one year, depending upon the level of training. In this approach, it is possible to eliminate duplication of efforts and to facilitate both vertical and horizontal

mobility.

Another major problem was identified in the transition between community colleges and four year programs. In order to establish easy upward mobility, it will be necessary to break-up the "credential barriers" that are presently stumbling blocks in the system. Since quite often the credit assigned to previous academic work is not determined by the particular program, but instead, by the general admissions policies of the college, the four year programs could establish a workable system of equivalency examinations to determine the capabilities of the individual in various fields and present this to the college. One of the problems in using standardized testing is that they are often geared towards a higher level of achievement and, therefore, might create just another barrier. To eliminate this problem, the system could be designed from the standpoint of minimal, acceptable achievement.

An important consideration in qualifying mobility is that, on the individual basis, the emphasis should not be on mobility, but based upon individual needs, motivation, and potential.

In summary, the areas discussed as avenues for facilitating change in meeting manpower needs in the educational system were 1) tackling problems of funding new programs, 2) creating a cooperative system in reaching common goals, 3) breaking-up the "credential barriers" between community colleges and four year programs, 4) orienting the whole system around individual potential, motivation, and needs.

Multidiscipline Workshop 1E

LAURENCE PEAKE, OTR, M.S., *Chairman*

PHYLLIS F. HIGLEY, M.Ed., *Recorder*

SISTER MARIA ELENA PADILLA, *Student in Community
College Teacher Preparation Program, Coordinator*

The discussion focused on the following topics: need for assistants, availability of faculty for teaching assistants, recruitment of students, relationship of assistants and professionals, educational career mobility and consumer utilization of assistant.

Discussion of the need for assistants took the group through a maze of questions but no answers or possible solutions seemed to be forthcoming. The more pertinent questions were:

1) Are there places for assistants or are hospital-trained aides now filling the need?

2) Is the professional allied health practitioner willing to delegate duties, heretofore professional duties, to the assistant—or will he guard them as the physician guards his duties?

3) Are we (educators) generating new programs in two-year colleges without pre-planning particularly in relation to availability of student and community need?

Availability of faculty is a major concern and few are really responding to it. One of the few successful efforts is being carried on at Buffalo, New York, School of Health Related Professions. The Buffalo project is known as the Community College Teacher Preparation Program and is an extension of the Kinsinger Study. Funded by the Kellogg Foundation and the State University of New York at Buffalo, the program accepts as students allied health professionals who have had at least three years of professional experience and who have a desire to teach their discipline in the community college setting. The program has no minimum academic requirements for admissions, is a ten-month certificate program and takes the students through a concentrated sequence of the discipline of education, and provides teaching practicum in the professional area of choice in local community colleges. Stipends are provided by the Federal government.

Recruitment of students poses unusual problems and two areas of pools of manpower appeared most promising:

1) Secondary Schools — It was emphasized that recruitment must begin at the 6th, 7th, and 8th grade level before students are locked into a high school curriculum. It was also emphasized that parents play a major role in career decisions and, therefore, major effort should be initiated to educate parents to the field of allied health. Besides early advisement, motivational programs must be developed. The Department of Medical Technology/SUNY explained their involvement with local secondary schools. Suggestion was made that support money be available for summer programs (similar to N.S.F. fellowships) to junior high school students.

2) Returning Veterans — The Federal Government is much concerned with the returning corpsmen who are being lost from the health manpower pool. The discussion directed the loss to the very rigid faculties who will not examine equivalent educational experiences. The Departments of Defense, HEW, and Labor are presently involved in Project MED HIC which offers counseling service at discharge centers for corpsmen interested in working in the health field after discharge.

The relationships of assistants and professionals seemed to produce the consensus that a communication gap exists between

the professional practitioner and the assistant practitioner. A solution may be found in the educational philosophy: students who learn together will more effectively work together as practitioners. It is suggested that shared learning experience utilizing health team concepts by various types of allied health students as well as various levels of students be formally planned and implemented.

Educational career mobility was discussed and it appeared that there is a real value and need for use of proficiency exams for allowing more flexibility in career mobility. Nursing is one of the only allied health fields which has developed proficiency exams. It was reported that the federal government is involved in a project aimed at proficiency testing for allied health fields.

Mr. Detmer's paper stimulated some comments on the consumer utilization of assistants. The discussion centered around the misuse and abuses by the hospitals and other medical institutions of the allied health worker. It was suggested that the consumer of the educational products be involved in the educational process as advisors and consultants so that understanding of the capabilities of the educational product can be strengthened.

Multidiscipline Workshop 1F

RICHARD A. CARTER, M.D., *Chairman*
THURMAN S. GRAFTON, D.V.M., *Recorder*
SISTER M. CONSILIA BUKA, *Student in Community College*
Teacher Preparation Program, Coordinator

It was difficult to limit discussion to the Allied Health Professions Assistants, because of the need to more clearly define their role and responsibilities as well as specific functions, within the total set of health care delivery systems. In trying to cope with this problem, we found ourselves frequently digressing into discussion of the physician assistant or the various kinds of nurses, since a definition of the assistant requires a (re)defining of the assisted.

The question of the certification or licensure as a significant factor in defining the role of the allied health professions assistant, triggered an interesting exchange on the subject of whether or not an assistant could or should be placed in a situation where he had to function independently with a minimum of supervision by one more competent in his own discipline. Examples were presented which relate to community health centers

which might have several satellite operating locations, relating back to a central facility with professional staff of a higher level of competence. The group seemed to feel that a general rule for all allied health profession assistants could not be drawn, since the nature of the work of the various technicians or assistants had differing levels of potential danger to the patient, i.e., some technicians require a lesser degree of supervision than others. On the other hand, it was agreed that in a large institution where a simple pyramidal organization assures close supervision of the assistant by the professional, there should be no problem.

The question of training vs. education came up time and again in many contexts. The implementation of the highly desirable concept of vertical mobility in the Allied Health Professions is complicated by the training vs. education dilemma. The crying need for more manpower to get specific tasks performed suggests the desirability of the short-time certificate program of strictly technical didactic training to get the job done. However, this kind of training alone does not allow the individual to progress directly into a professional level educational program. On the other hand, the amount of general education required in a two-year degree program prolongs the time necessary to produce an individual to perform the same function.

The economic implication of the differences in reaching the same level of technical competence was discussed as a concern to both the student preparing for an occupation and to the patient who ultimately has to pay through increased hospital costs, for the higher level of education of the technician.

Actual experience of members of this workshop suggests that the two-year terminal degree programs in the Allied Health field vary greatly in both content and quality of instruction, making it extremely difficult for a baccalaureate program to integrate graduates of such two-year programs into their baccalaureate professional program without requiring considerable, if not total, repeat of subject areas.

One of the problems of providing a clear line of vertical mobility discussed was the amount of general education required for both the associate and the baccalaureate degree. All were in agreement that an educational program must have some general education and particularly sufficient social studies and humanities to teach the student in the allied health professions to relate to the patient as a person and not merely a functioning mannikin. It was pointed out, however, that the dose of general education might be more than the student really needs, and is delivered in too big a package too early in the game. It was felt that this resulted in many students who had initial goal

orientation to a health profession being discouraged and dropping out either from a feeling of time wasted, lack of interest in the subject matter, or financial difficulty before ever reaching that part of the curricula related to their prime interest.

It was suggested that the optimum curriculum would provide in the freshman year some general education and specific orientation to health careers in general and basic related subjects such as biology. The second year could then be devoted almost entirely to didactic training pointing towards a specific allied health profession assistant capability. This would allow the individual at the end of two years of college to achieve an associate degree and be eligible for whatever certification or licensing might be required to function as an effective member of the health care system.

Such an individual when ready to continue his education either with or without interruption, could be enrolled directly into a baccalaureate degree program at the third year level. Additional general education, particularly the humanistic courses, could be readministered in small doses, along with training in supervision and management, since it is anticipated the development of formally trained assistants will, for the most part, push the baccalaureate level professional into a supervisory role. At the same time, the baccalaureate program would include an upgrading of the level of sophistication of the didactic portion of the curriculum.

In nursing education, it was pointed out that since the two-year degree programs were producing graduates eligible for registration, most hospitals have arbitrarily been placing nurses with a baccalaureate degree directly into supervisory positions in recognition of their added education. However, it was shown that very few if any of the baccalaureate nursing programs include management and supervision as a specific part of the curriculum.

An interesting side debate related to the organization of a health care delivery system. What level of technical competence should be the first to contact the patient? (i.e., should it be the Doctor of Medicine who has been specially trained in diagnostic skills in order to recognize the more subtle medical problems, and channel the patient into the specialized areas for further workup and treatment; or on the opposite extreme, should the patient's first contact be with an aid-assistant-technician, who is authorized and trained to provide diagnosis and treatment of the simplest nature with more competent nurses, physician assistants, or physicians on call for problems they recognize as beyond their scope?) This led to a discussion of the various specialties for physicians in an attempt to identify who the highly

trained diagnostician was in terms of existing specialties. It would seem such a specific specialty does not currently exist.

Another subject discussed was the important service that can be provided by properly designed equivalency testing, a means of equating the kind of training and experience that a person may have received in the military medical service, or as a result of on-the-job training, with that of students formally trained in either certificate or associate degree programs. It was agreed that such testing should not only serve to verify the competence of the individuals to perform that specific assistant role, but also to qualify them for entrance at the third-year level of a baccalaureate program, whether they had actually had any previous college credits or not.

Another interesting point was brought out in trying to relate our discussion to the patient. The "team approach" while professionally ideal, exposes the patient to such a vast number of individuals of varying degrees of technical competence, that it is very easy for the patient to get confused, and thereby alarmed regarding his own well-being. It was suggested that part of the problem is the result of the columnar organizational structure in most hospitals in which the various health workers communicate directly only with those working in their own basic discipline. It was agreed that there is a great need for more communication of an interdisciplinary nature of the various health workers.

This led to some discussion about the desirability of more positive effort to familiarize those in the health professions of the role and responsibilities of other members of the health team. It was generally agreed that for most of the health professions, this was pretty much neglected in the often erroneous assumption that merely being placed together in a clinical environment would have this knowledge rub off and be assimilated in a usable form.

Multidiscipline Workshop 1G

MICHAEL CARPENDALE, M.D., *Chairman*

HELEN LEES, MT (ASCP), Ph.D., *Recorder*

JANICE JUDD, *Senior Student in Medical Technology, Coor.*

Dr. Carpendale initiated group discussion by posing several questions. Is there a need for more people in the health fields? In U.S.? Why? Why is it increasing? What should be done to meet the need? What are the main objectives for a program to

improve health care? What are the primary obstacles?

In tackling these questions, discussants pointed out that the U.S. is second only to Israel in the physician:population ratio but U.S. has a greater number of allied health workers. In spite of this, there was general agreement that more health workers are needed. These needs arise out of, and are predicated on research findings and improved technology, improved treatment methods and the concomitant rise in the use of pharmaceutical agents. The latter, it was pointed out, calls for careful monitoring (i.e. more tests required) to guard against undesirable side effects. Medicaid and Medicare legislation has brought about increased facilities, particularly the extended care variety, and made care available to a greater number of people. The increase in population and standard of living add to this growing demand for health care and this calls for an ever increasing demand for more and more health workers. In discussing the "needs," participants considered the issues of distribution of workers, the sometimes unnecessary use of diagnostic tests, and the waste attendant with repetition brought on by a mobile society.

With these general impressions of the reality of need for increased health manpower, the group turned its attention to modes for meeting the needs. One of the first steps would seem to be a more detailed analysis of the manpower needs to determine the critical areas and to attempt a better distribution of needed personnel. One approach might be a look at the geography of health care with a special note on rural and inner-city areas where the needs appear to be most critical. In this way shortages and saturations would be pinpointed and realistic efforts expended to encourage a redistribution of personnel and a new look at facilities.

The increase in personnel should include, the group suggested, more assistants in various fields, more people at higher levels for supervision, teaching, and the starting of new health care facilities. Tasks might well be critically analyzed to determine level of competency needed and then develop personnel to accomplish these tasks.

In addition to task analysis, the group saw merit to increasing recruitment, particularly of males; provide child care, home-maker care, refresher courses and increased use of part-time help to attract and utilize professional women who have withdrawn from the field. Salary came under scrutiny and it was conceded that health care workers, particularly at the assistant level, are not paid well enough to keep them in the field. As a final thrust at the employment environment it was felt that much could be done in the areas of improved management and organization.

Continuing with the discussion of meeting the needs, the broadening and improving of teaching and training programs was introduced. Assurances should be given that properly trained people will be used as instructors; that thoughtful *concern* be shown for the students to avoid an attitude that they are just extra hands for the scut work. Too frequently the teaching is done by students, assistants, aides, and others not properly qualified to teach the discipline or skill in question. This problem is bound to increase as new types of assistants are added. Other avenues for resolution of the problem included subsidization of the college student; reduced training time; continuing education for those in service and refresher courses to attract "drop outs" back into the system; and increased enrollment in all of the major disciplines.

The cost of medical care arose as a related item and the group believed this to be part and parcel of improved care. They suggested that increased use of out-patient facilities might follow a broadening of insurance coverage to include this service and thus reduce instances of hospitalization for diagnostic work-up. Organized home care programs with increased attention to home health aides might serve to extend services to the poor, contribute to preventive medicine and permit earlier discharge of patients otherwise recuperating "in house" because of inadequate care at home. Increased efficiency of patient handling and computerization of medical data on all patients was suggested as leading to earlier treatment and reduced repetition of tests, etc.

A major area for improved patient care can be found in greater attention to preventive medicine and dentistry. Mass education, health checkups, multiphasic screening and improved environmental health were seen as significant items in preventive care.

The primary obstacles in meeting health needs are shortages of facilities, personnel and money. It is important to use present facilities and personnel as efficiently as possible. Funds are needed to improve efficiency as well as to increase the number of workers and services; both Federal and State governments will have to provide these and this truly calls for re-education of legislators at local, state and national levels.

Multidiscipline Workshop 1H

EDMUND McTERNAN, M.P.H., *Chairman*

TERRY KARSELIS, MT, B.S., *Recorder*

JOHN WIECHEC, *Senior Student in Medical Technology, Coor.*

The train of thought that emerged from the discussion seemed to be in the following vein:

1. The participants agreed that there is a critical health manpower shortage. The question that arose was why?
2. One reason for the shortage seems to be poor utilization of the present workers in the field. Once again the question is why?
3. The consensus with reference to the above question was that there is a lack of definite role identification at the national level. Why?
4. Cooperation between educational, service and peer group organizations is lacking.

The conclusion to be drawn from such a train of thought implies that before assistants can be effectively utilized in the health related professions their roles must be defined. To accomplish this requires better identification of all the roles that presently make up the ladder of mobility within a particular discipline, based on the tasks that are performed at each level. Such analysis requires cooperation and communication between educational and service institutions as well as peer group organizations at a national level.

In attempting to isolate problems related to poor utilization of health manpower the participants generally agreed that the concept of clearly defined roles exists, but that it is not adequately applied. For example, the difference between a technologist and a technician is at present based more on education and economics than on task performance.

Proponents of certification see such regulation as a better method of identifying roles. Others see it as being only a numerical evaluation not a behavioral evaluation and consequently not functioning in role identification.

The idea of using licensure to ensure a level of competence and, therefore, assist in role definition was brought to question, since many participants agree that it (licensure) indicates only that an individual is safe to practice and it does not indicate at what level he will practice. In addition, the motivation behind licensing was questioned since some viewed it as a method of protecting group interests.

If and when clearly defined roles within each discipline are identified and recognized on a national basis, proficiency testing can then be developed that will provide the desired mobility within these disciplines; but even more important, roles once they are clearly defined become objectives and provide the motivation to make the individual improve himself. At present such vertical mobility within some disciplines is theoretical rather than practical resulting in dead-end careers.

SUMMARY

1. All participants agreed that the shortage of health manpower is critical.
2. There is mixed opinion on how to alleviate the shortage.
 - a. Some advocate instituting the role of assistant.
 - b. Others advocate better utilization of assistant personnel without introducing new categories.
 - c. Others still advocate application of both of the above.
3. The participants seem to agree that the poor utilization of the health workers presently employed can be traced to non-existent or hazy role identification.
4. Most participants agreed that nationally recognized and accepted roles in each discipline must be identified.
5. There was mixed opinion as to the possible aid certification and licensure (as presently found) would provide in helping to define roles.
6. All participants agree that to draw and keep increased manpower into the health related professions requires motivation and that motivation will only result if there is mobility lateral and vertical within each discipline. This mobility must be a reality, and not just theoretical, to result in the removal of dead end careers.

Multidiscipline Workshop II

ANN PASCASIO, Ph.D., *Chairman*

JOAN FISH, OTR, B.S., *Recorder*

JON CAROL MOYCE, *Senior Student in Occupational Therapy, Coor.*

Dr. Perry's provocative paper on the subject of the mobility of the assistant became the jumping-off point for this group's discussion. The group readily agreed that mobility was not only desirable but almost mandatory if top quality personnel were to be attracted to the assistant role. Buttressing this was the idea

that once involved in the study of patient care and in actual practice, the desire to advance would be a hallmark of the dedicated worker. The factors making for impeding or ease of mobility were not so easily identified or resolved. One of the critical factors to be initially approached is the education factor. Since upward mobility calls for new knowledge, new skills and new responsibilities, there is a concomitant need for more education. In this respect the group talked of the laterality of education and suggested that one-half of all education in the health field should be human sciences and laboratories and the other half devoted to specific disciplines. It was revealed that at some schools (notably at New York City and Louisville, Kentucky) some attention is being given to a study of differences and similarities in existing assistants training programs and that from such research efforts, meaningful, transferable core curricula might be established. Examples given were core courses in Medical Technology, Community Health, the team concept and Environmental Health. In addition to the transfer of credit value of such courses, the group saw them as vital to the team concept when studying together leads to mutual appreciation and basic knowledge of each other as individuals.

With these baselines, the group sought to define the concept of the assistant and accepted the path of defining by example. A look at nursing led to the belief that with RN-degrees, RN-nondegrees, LPN's and aides, the "assistant" is just another title. Medical Technology, with its increased automation was seen as coming a bit closer to the accepted idea wherein the assistant does the more technical tasks leaving the technologist free to interpret the tests and aid in suggesting further diagnostic approaches. This raised the question of whether this takes something from the physician's role and it was agreed that this aided and enhanced the physician's role since the technologist is now free to consult and advise in areas where her/his knowledge of tests, reactions, etc. may be equal to, or in selected cases, superior to that of the physician.

Mr. Detmer was called for during the discussion of the identity of the assistant and at his arrival, the group went back to that issue. Mr. Detmer suggested that one of the problems facing hospital administration was the difference between persons functioning within a given service. He cited nursing where one has orderlies, aides, LPN's, RN's without degrees, RN's with degrees and others with even higher degrees. Realistically, Mr. Detmer suggested that less emphasis should be placed on *who* does the job and more on *how* it is done in terms of value, quality and improved patient care.

The issue of legal implications seemed to stem from the lack

of definition of responsibility on who (?) and Mr. Detmer suggested that perhaps as laws are tested that they will change to accommodate the true team concept. However, it was added that a precursor to such changes must be changes in attitudes which will allow for greater creative use of manpower. The group then seemed to wonder if the whole system of health service needed changing from recruitment and selection on through the education and into actual delivery of care. In response to this, Mr. Detmer referred to Julian Richmond's "Currents in American Medicine" and to Robertson's article in the March 1970 issue of Blue Cross "Inquiry" suggesting that the study of the selection of physicians and the need for health care balance appeared to be suggesting rather wide sweeping changes. The trend of the hospital administration is for the hospitals to become more extrospective, that is, to extend into the community as in neighborhood health centers and extended care facilities. With this *must* come changes in roles, role-relationships and responsibilities for the health worker. For example one could ask and study of the value of the lattice, the lateral transfer. . . can a person serve adequately in more than one discipline, what additional training would an Occupational Therapy assistant need to function in Physical Therapy? In Nursing? In Medical Technology? Perhaps a system that would allow upward (ladder) mobility through added skills would be better.

Turning their attention to licensure and certification, the group called on Dr. Leuallen asking, initially, as to the kind of licensing best suited to the assistant. In responding, Dr. Leuallen suggested that we draw on experience but cautioned that we not be confined nor constricted by it, not so rigid as to find licensing consigning the assistant to a small, rigid sphere of menial tasks. Dr. Leuallen suggested that whereas certification did, by definition of title, limit role and function, licensing gives the individual the continuing opportunity to practice with only the minimal of supervision. On the question of federal or state licensing it was agreed that the fifty states could not presently agree on standards. Without this, geographical mobility would be seriously impeded if not impossible without loss of experience. Much needs to be done, there are many, many hangups and one wonders if licensing is, indeed, necessary? Some states are turning to "boards of review" as the unit to give qualifying individuals the right to practice. This discussion led into the "pass-fail", "student-involved" program or course patterns and, under the assumption that these features tend to lower standards (a debated premise) it was suggested that the schools should not be expected to certify students. It was recognized that this might not apply to professional studies. However there was evidence that profes-

sional schools are moving in this direction. At this point and near the end of the session, the group considered qualifying examinations as one answer to the above as well as instruments to extending advance standing to students, returning veterans and those who were desirous of re-entering the health care field.

Multidiscipline Workshop 1J

CHARLES CHAPMAN, Ed.D., *Chairman*

DANIEL L. STEINBERG, LPT, M.S., *Recorder*

LINDA L. ATKINS, *Senior Student in Physical Therapy, Coor.*

The discussion followed a period of introduction of all participants of this multidiscipline workshop. The group was initially concerned with the establishment of government sanctioned licensure and certification of assistants and professionals.

Dr. Leuallen provided us with some insight as to how New York State believes licensure and certification should be established by the profession. He recommended that professional groups establish standards and submit them to the State and that there should be prior professional representation on the licensing board. This implies that all health professionals should share in the responsibility for the delivery of health care, and that each allied health profession should recommend to the state the limits of licensure and certification for its members. It appeared to be unanimous among the participants present that the burden of governance and control should be the providence of each of the professions.

It became apparent that we were discussing a subject without clear definition of the difference between certification and licensure. Dr. Leuallen described licensure as the exclusive right to perform an act or service, and to control that area in which one is licensed. He continued by describing certification as the recognition by the state that one can perform an act or service proficiently, but does not have sole propriety to perform that act or service. To further clarify certification it was pointed out that it is illegal for a practitioner to call himself certified, if, indeed, he is *not* state certified.

There appeared to be a consensus that allied health assistants should be certified so as to promote lateral and vertical professional growth of the assistant. The experience of licensure teaches us that the academic requirements for licensure for a profession are too rigid and restrict manpower development through intra and/or interprofessional growth. Dr. Leuallen suggested that the

development and utilization of proficiency or equivalency tests should reduce the limitations imposed by academic requirements.

Several individual professional problems were brought to the discussion by the participants. They appeared to focus upon groups who worked for other professionals (dental hygienist, medical technologist) and who did not share the responsibility of health care standards, or modes of delivery, and who did not have representation on state licensure boards.

Interestingly enough, Dr. Leuallen pointed out that the Allied Health Professionals have been their own worst enemy in selling liberalization of the laws and regulations of practice. He said, "We talk generalities and practice within rigid, inflexible structures" that do not lend themselves to change, liberal or otherwise.

A Cuyahoga Community College faculty member inquired as to the minority population in the allied health professions schools, both professional and assistant programs. A consensus of the representatives of community college and university programs present indicated that the minority students, in particular, black students, were most critically in the minority. It was concluded by the discussants that recruitment of students seems to be hindered by two major phenomena:

1. The allied health professions are seen as maids to medicine, and, therefore are avoided by prospective students;
2. The educational institutions are not readily responding to the "Issues of the Day" by
 - a) not liberalizing transfer credits, and by
 - b) maintaining rigid departmental standards.

The "Upward Bound," "SEEK," and "EPIS" programs appear to be providing more minority students to all schools in general. The problem that has presented itself is that graduates of these programs do not return to their communities to encourage others to join the educational "bandwagon." SUNYAB has an independent study group who are recruiting for education and the allied health professions by initiating college student contacts with young inner-city children who are in the fifth through seventh grades of public schools. It is anticipated that these inter-personal relationships will be the media by which the value of education and interest in the health professions can be fostered. From this discussion it appears that the schools are recruiting more black students but that these students have a written and verbal language barrier even though they appear to perform adequately in the clinical programs. This indicates that educators must avoid utilizing standardized academic evaluations, and develop new, innovative ways of guiding the minority students' educational

objectives.

Dr. Perry joined the discussion when the topic changed to the question of lateral mobility. Who and how many? From the discussion it was apparent that the lateral mobility is induced by the commonness of function, and that those professionals in the schools are more likely to move laterally than are professionals in clinics. That is, if we assume that administration is not a lateral move. To facilitate this mobility the schools should search for the common ground of each health profession, and develop a core curriculum for all health professionals.

Dr. Perry was asked, "What is the feasibility of focusing undergraduate study on preparing 'generalists', and the graduate study programs developing 'specialists' of a specific allied health field?" Present medical philosophy and practices prevent the attainment of this ideal, but there are ways of facilitating lateral mobility by working within the present system of associate degree and baccalaureate degrees. The health professionals are not prepared for a 'generalist' because the health practitioner is usually performing within a rigid specialty. Therefore, it is suggested that training in the schools be flexible in scope rather than general in performance. There was also fear of rising hospital cost for training the 'generalist' once he has graduated. The rebuttals to this statement were:

1. The advantage of in-service training to staff and patient care.
2. The advantage of "generalists" to work well with many with understanding.
3. Reduce cost by ability to perform many tasks inter-departmentally.
4. Encourage the individual's opportunity and choice to horizontal or vertical growth.

Throughout the afternoon discussion there seemed to be a mainstream of thought and consideration for the job description, task analysis and/or limits of responsibility for professionals and assistants. The suggestion was made by the recorder that the professions re-evaluate what they consider to be optimal patient care that is singularly and collectively, within the scope of each of the health professions. Once this evaluation is complete we will have readily definable, broad limits of responsibility and guides for utilization of assistants. From the results of this evaluation the schools of allied health professions can develop educational objectives which will meet the health needs of the community in the professional as well as the assistant programs. This approach will also facilitate professional growth that, in turn, will minimize the fears, restrictions, and servitude that is

felt by so many of the people in health related professions.

In summary, there was a unanimous expression that all professionals, in their evaluation of optimal health care, avoid the hypocrisy of preaching flexibility and practicing rigidity. There must be a realization that there is overlap of responsibility in optimal health care delivery and responsibility and therefore, strict limits of responsibility are impossible to define. The health professionals must be made aware that rigid limits of responsibility are a deterrent to manpower development and optimal efficiency in health care delivery.

The Role of The Assistant in Medical Technology

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The mission of the health professions today is to provide not only the comprehensive and quality health care for which the public has expressed their desire, but also to provide the health care services yet undefined that will contribute to greater health of our nation. Therefore as we plan for the future, increasing consideration must be given to preventive and environmental health as well as continued development of the diagnostic and therapeutic care of the patient which has been the major emphasis in the past. If these three concerns are to be efficiently ac-

complished, they should be incorporated into our comprehensive planning; then logical components of the overall plan can be identified to program and deliver efficient and effective health care.

The medical laboratory, as a sub-system of this larger system, must plan for the future by identifying "that where and the when" that our services will be needed in tomorrow's system. The general definition of what our services will be emanates from a basic core of current scientific knowledge which is a constantly changing dimension.

The next and perhaps most critical parameter to consider before defining who is needed to provide the service, is to determine how the production of these services will be organized in the delivery system — an organization that is compatible to the total system and yet one that is planned in an efficient and effective manner. Is there a bridge, an additional link, or a new element that will take us from where we are now to a more comprehensive and efficient method of service?

These are some of the general factors that must be considered to define the need (or problem) which must be the first step in planning for change. Conservation and logical planning of all resources is important — money, time and human resources — but the most valuable of these resources is the human resource in that it is the only element that can grow and develop. This concept is inherent in current discussions as we are defining and planning for career mobility, innovations in education that focus on the mechanism of learning rather than a focus on specific knowledge, equivalency measurement of competency attained toward identified behavioral objectives, and work-study programs that facilitate growth and development through performance.

If these are meaningful objectives, these must be considered in the overall planning of the career line — both the ladder and the lattice or even a three, four or five dimensional model, whatever evolves as logical in the detailed development of a system now defined as a "non-system". Care must be taken to assure that service and management principles develop concurrently with educational planning for mobility, lest we end up with just a greater number of boxes rather than a truly permeable structure. This then requires the involvement, participation and indeed leadership of the practicing professions in defining change. The articulation of the need or problem from the total system and the demand for accountability from the sub-system (the practicing professions) for their responsibilities must be explicit and clear. Indeed I know of no other system in our society that

is more adaptable to the concepts of team management than the health care system.

Let us assume that we in medical technology have identified our problem correctly and that an additional level of competency, which we are calling an Assistant in today's discussions, is indeed the need. Volume of services, range and ratio of capability needs, specialization, automation, organization of service facilities, and manpower needs are all factors that are inherent in the identification of the need for an additional competency level in the laboratory.

The next step in the rationale of change is to analyze the entire range of services in our professional specialty from the very top to the most basic function. The process of task analysis of the entire career line provides the needed information of how tasks are performed, how they relate to patient needs, and the necessary performance requirements of each task. Then from this information tasks can be grouped to formulate the job descriptions. If we are committed to maintaining potential for career mobility, then during the organization of tasks into jobs one must focus on the grouping of both skill and knowledge components within a career line so that additional capabilities that lead to the next level of performance can be gained through performance and study endeavors of the individual. This leads to long range productivity of the human resource through built-in motivational factors which facilitate growth and development of personnel.

From this philosophy it is evident that the introduction of additional levels requires an evaluation and redistribution of tasks up and down the career line and an incorporation of change at all levels. Job descriptions created through this analysis process then become a plan or an adaptation to changing needs rather than adoption of an informally defined job by individual institutions that meet individual institutional needs. At this point the job can be properly titled to reflect the functions, duties and relationship to the career line. The appropriate sponsor or management responsibility for the category should be delineated and charged with the accountability for the services of the category. The task analysis will also greatly assist in identifying the necessary components of the educational program, how it should be organized and the additional learning potential of the work performance. Similarly as a career line undergoes change and mutation, other positions (through redefinition) will have changing educational programs and indeed perhaps retitling of the position.

These are the basic steps that should be followed in introducing a new category into the career line. In this process several

considerations should command our attention.

1. Even with a focus on the tasks, the perspective of the individual should always be carefully considered. Job definitions without concern for the development of the human resources returns us to the Taylorist's theory of management of the 1930's.
2. As change in services creates new skill demands to provide the services a plan for flexibility, easy transition and augmentation of skills of personnel must be developed and continually revised to maintain relevance to manpower needs. This requires an organization of the educational process with primary emphasis on this continuing process. Automation and increased complexity of laboratory testing places a rising premium on higher scientific skills and renders some of the basic skills redundant to the automated instrument. Changing needs should result in a redefinition and transition of existing human resources and thus retain these individuals in the manpower pool. This must be ensured in the basic education programs and development continued through performance experiences and continuing education.
3. Application of current management practices that build and expand personnel capabilities rather than a deterioration of this vital resource is mandatory. There must be room for expansion or stretching of the individual within a given level of the career line in order to provide a mechanism for management promotion. Just as there is a hazard of steps that are too broad between categories, likewise they can be too tightly packed for sound management.

A review of the evolution of the current assistant category in medical technology reveals several deficiencies in the steps previously outlined. As an end result I am sure the role is less effective than it should be. First, a task analysis of the career line was not carried out, but rather the category was defined by adoption of individually created jobs in the field. Secondly, an educationally "dead end" program was established. Third, though the category was defined as an assistant to the medical technologist, medical technologists were not allowed to sponsor the program and assume the accountability for the performance. From a management perspective this decision abrogated a basic management principle — bypassing the role and defined level of responsibility of medical technologists in the laboratory career line. Erosion of management relations could be expected, and indeed it has resulted. Unnecessary barriers within the career

line spring up and extensive efforts have been expended to remove these barriers.

In spite of this illogical creation of the assistant, the need and value of the assistant is clearly evident. During the eight years of the program, a more appropriate definition of the role has evolved. A recent survey of the graduates of the program delineating additional educational needs and the current development of educational programs within the framework of junior colleges are resolving some of the inadequacies. The assistant was conceived to work under the direct supervision of the medical technologist and provide direct assistance in basic duties to the performance in each discipline of the laboratory. However, in the actual utilization, several other conditions have prevailed as over-riding factors:

1. The shortage of medical technologists has created an employment pattern where the fully prepared medical technologists have tended to seek employment in larger urban and metropolitan medical complexes because the depth and technical aspects of these positions were more challenging. The smaller facilities and geographically remote areas have had difficulty in attracting medical technologists in the highly competitive employment arena.
2. The majority of testing procedures performed in these facilities fall within the scope of training of the assistant, therefore the day-to-day patient needs are primarily fulfilled. The lack of theoretical knowledge of the assistant to competently meet the unusual and abnormal incidents, to incorporate technological changes, and to introduce new and modern services is an underlying problem rather than an immediate problem when facing vacant positions in a competitive employment market.
3. The lack of consideration of the entire career line and traditional practice barriers has precluded the evolution of consultation or indirect supervision by medical technologists to increase the effectiveness of this employment pattern. In recent years this role of the medical technologist in relation to the assistant has been established in scattered instances. It has proved to be quite effective and has enhanced the role of the assistant as well as the technologist in the provision of services of the profession.
4. In a survey of certified laboratory assistants conducted in 1969, data showed that the assistant was utilized in 12 instances (970 reporting) in a teaching role in the educational programs for medical technologists. The reasons for this were not cited and to my knowledge, it has not been

further researched.

The most valuable role for the assistant from a perspective of task analysis in relation to their current training, is in the larger clinical facility where more extensive stratification of jobs is possible because of the volume and scope of services. Traditional staffing patterns of only registered medical technologists and the on-the-job trained aide are changing as facilities are tending to increase in size. Incorporation of the assistant in staffing patterns, which are requiring a broader range of capabilities, is increasing the demand for this level of competency. The increased complexity of tasks on one end and work simplification through industrial developments (instrumentation and methodology) on the other end, has been a major factor in the changing personnel needs. The technical advancements and the search for more economical methods of providing services is increasing the need for centralization of services, which will further increase the utilization of the assistant.

With these major and rapid changes, an evaluation and realignment of the entire career line is desperately needed. A "grow-like-topsy" pattern for change would be a serious error. The concept of dual or tri-promotional ladders within a profession which represents a promotional opportunity through multiple performance routes, e.g. technical performance, education or management roles rather than dual or triple careers within a career line is an important potential to maintain in future organization of the profession. With appropriate continuing education, structured work-study courses, academic courses and work experiences, the necessity for multiple "ports of entry" at advanced levels in the career line would be decreased and career mobility opportunities would be increased.

Frederick Herzberg identified in a motivation study that the positive motivators were the factors that provided opportunities to become more expert in one's occupation and to be able to handle more demanding assignments. If this can be built into the career line beginning with the very basic positions, the reward would be a retention of human resources in the profession, maximum development of our resources and a better quality of services through elimination of costly turnover.

Medical Technology is in the process of restructuring the assistant role in our profession. Recently, guidelines have been developed for the associate degree program for medical laboratory technicians even though programs have been presented in some junior colleges for many years. This program is now being formalized in the career line in addition to the current program for Certified Laboratory Assistants which is a one year hospital

based non-academic course.

In comparing the guidelines for these two programs, the competency of the individual upon completion of the program will be essentially the same, therefore their beginning performance in the profession will be at the same entry point and job definition. Because of this lack of differentiation in performance definition, the validity for two different certifications is questioned by many at this time. Clearly the major difference in these two certification categories, is the mobility potential for the MLT as compared to the "dead-end" of the non-academic CLA program. The MLT will have an educational orientation and recognized credentials that will provide the opportunity for education and experience advancement through the academic base of their initial program.

Many CLA programs have or are planning to convert to the MLT program as a more valid component of the career line needs. Another alternative is to revise the current CLA program to a more basic program with a decrease in scope which would then be a step leading into the MLT program. If these programs were based in vocational-technical high schools or post-secondary schools, the potential for academic mobility into junior college programs could be developed.

Another concept under discussion at the assistant level of performance is the feasibility of specialization in a specific laboratory discipline. I believe a comprehensive task analysis is absolutely necessary before we embark in this direction. The concerns of unnecessary fragmentation versus valid specialization in allied health professions in general, certainly should be considered in an intro-laboratory evaluation. Again this should be an evaluation of the entire career line and appropriate realignment of the entire line studied and planned. The expedient solution to current needs often creates greater problems for the future rather than building a sound foundation. Progressive steps toward the long range solution must be earnestly sought.

Peter Drucker states in his article, *"Management and the Professional Employee"*. "Some companies, to be sure, want technicians rather than professionals—people who are good and quick at doing the immediate, assigned job and no more. But these companies not only fail to attract really good people (or will lose them if they get them), they will also deprive themselves of the major contribution that the professional individual can make, which springs directly from his creativity, his standards, his refusal to accept uncritically management's definition of the problem."

Care must be taken that we create a pattern in the education

and practice of our profession so that the assistant or any other level of performer can see a way to progress complimentary to their initiative and capability. The climate and environment of the profession is a major factor in achieving these goals which will in turn improve our performance in the total health care system.

Discussion Workshop

ROMA BROWN, MT (ASCP), B.S., *Chairman*

SARA MARIE CICARELLI, B.S., *Recorder*

SUSAN HODES, *Senior Student in Medical Technology, Coor.*

The Medical Technology Workshop of April 17, 1970 was well attended by representatives from many areas in the field of medical technology. Although the discussion focused on the role of the assistant in the clinical laboratory, it also included those at the baccalaureate, masters and doctorate levels.

The session opened with the point that all the Allied Health Groups should get together and find out each other's roles toward the patient since our common concern is the patient. It was also suggested that this should start at the student level.

The first question concerned the Certified Laboratory Assistant (CLA) and the possibility of a CLA phase out. A representative from a two-year school seemed to feel that there are more CLA's in the hospitals now and that he could see more coming. Those disagreeing with this view felt a phase out was inevitable because of the terminal nature of the CLA. With this, the question of equivalency testing was brought up. Roma Brown said that the trend seemed to be moving toward this, which would also allow for greater mobility. A transfer student from a two-year technical school was asked about his curriculum. He seemed to feel that it was only a matter of a few liberal arts courses that had to be made up, and only in some courses was there repetition. But he also felt that credit should not be given point for point, but on the basis of what one knows. This could be done by equivalency testing. Equivalency testing will also allow for more mobility.

The lack of uniform training was discussed. A representative from a two-year program said that a committee should be set up in the state concerned with the programs in schools, so as to have better communication among schools. At Farmingdale there is more theory in the first year and not just technics. When the students go to the hospital in their second year, they devote more

time to technics with emphasis on precision and accuracy. This particular school felt there was complete cooperation between the school and the hospital. A statement was made suggesting programs in four-year schools with reverse training to allow these students easier upward mobility.

The program at SUNYAB was then discussed. It was noted there is no uniformity in the senior year due to the number of teaching hospitals. A faculty member stated the need for an interface with more interaction and coordination between the campus academics and the hospitals.

This led to a discussion of differences between the technologist and the technician. Due to increased automation in the laboratory, it was felt that the technologist will have to be educated at a higher level in order to evaluate results, rather than just record them.

Three areas for future technologists' education were suggested, e.g., supervisors, teachers and researchers. A participant from Strong Memorial Hospital stated that even with this there is still a great need for the technologist to do routine work and gain a certain amount of practical experience. Two-year programs should train technicians to do routine work. The baccalaureate programs should not produce technicians. Several people made the remark that an employer depends on the ability of the graduate with a baccalaureate degree, and that he should be able to perform with a minimum amount of supervision. Our present educational programs produce the motivated and non-motivated. An example of the non-motivated is the four-year student who is satisfied to perform as a technician or a technologist that must be constantly supervised. The motivated will make a job what they want it to be and perform more independently. A major problem is that many hospitals do not discriminate among the CLA, the MLT and the MT, and all are within a narrow salary range. The question of how duties are divided brought the response that state licensure laws are including a differentiation of task levels. Should this be the same for both small and large areas?

Then Roma Brown brought up the question of the relative roles of the MLT and CLA. She said that the Board of Schools is working toward a separately incorporated Board of Schools that would establish essentials for various levels of education after defining the role for each level of education, e.g., utilization and task analysis. It was also stated that training at the assistant level should be organized as a generally based program. The assistant could be mobile and serve as a general health assistant. The need for a one-year assistant, without realignment

of utilization of the medical technologist and the technician are not fully utilized, was questioned. There was no response to this since technologists have not defined a need for two levels of supportive personnel.

The last few remarks were not discussed as thoroughly. Someone asked why students do not go into rural areas where medical technologists are really needed. The general response was because of less challenging work and uninteresting locations.

Another question was asked about continuing education and teaching. Continuing education programs are through conferences, like this one, seminars and professional organizations, but Graduate School opportunities are very extensive for medical technologists, including Ph.D. programs. As for teaching, the general agreement was that to teach, experience as well as some further graduate education was necessary. Direct entrance upon graduation into Graduate School was not discouraged. It was felt that individual evaluation was preferable to blanket rulings.

This session concluded with the following observations.

1. That there is a shortage in laboratory personnel.
2. The shortage of personnel would be less acute if there were proper utilization of the existing personnel.
3. There is urgent need for task analysis and utilization study in order to improve the educational programs at all levels of entry into the field of medical technology as well as to achieve more efficient utilization of personnel.

The Assistant in Medical Records

MYRA ENKELIS, RRL, B.A.

*Chief, Medical Records Librarian
Columbia Presbyterian Medical Center*

I have been asked to talk with you today about the medical record technician, the trained assistant working in medical records. I'd like to take a few minutes first to describe the work which is done by medical record personnel in general and to explain a little about the professional level personnel, medical record librarians. I hope this will help to put the role of the assistant into perspective, both as to his functions and to his potential for mobility.

"Medical record personnel provide a wide range of health information services: in direct-patient-care institutions, such as hospitals, clinics, extended care facilities and nursing homes; in local, national, and international government and voluntary health agencies; in business organizations and commerce; and in academic and other educational activities."¹

The largest portion of medical record personnel are employed in the direct-patient-care institutions. The role of medical record personnel in these institutions encompasses a variety of functions and, therefore, numerous technical skills. These skills are exercised before, during, and after a patient's hospitalization. In the typical hospital, the Medical Record Department begins its activities on behalf of the patient prior to or immediately upon his admission, since this is the time when the record of his care begins. The Medical Record Department is concerned at this time with such matters as reactivating an existing record of the

¹American Medical Record Association, *Functions of Medical Record Personnel*

patient or preparing for the creation of a new one. During the patient's actual hospitalization, the Medical Record Department continues to perform functions related to his stay. One activity usually consists of either producing the daily census or verifying the data on a census produced elsewhere in the institution. In a large institution, this is an activity which can become an exceedingly complex procedure, particularly as the patient is transferred from one physical location to another or from one medical specialty to another.

Another function is the provision of dictation facilities and transcription services for the recording of history and physical examination, progress notes, reports of surgical procedures performed, or finally a summarization of his total stay.

If the patient gives a history of medical treatment given by another physician or in another institution, the Medical Record Department may be asked to contact the appropriate parties to secure copies of records pertaining to this history.

If his condition happens to involve any item of public health significance such as a communicable disease, a suspicious injury, a birth, or a death, the department may be responsible for preparing the necessary certificates or filing the required reports with the appropriate governmental agencies.

If the patient's stay extends beyond a prescribed number of days, or if the patient happens to be covered by the Medicare program or a related State medical insurance program, another function may be that of requesting periodic reviews of the case by physicians and reporting on the results of those reviews.

While all of these activities I've been describing constitute important parts of Medical Record Department functions, much of the work of the department begins only when the patient has been discharged. At this point, the record itself finally reaches the department. Statistical data are gathered, for example the number of days of care given, or the characteristics of the patient such as age and sex, or the final disposition of the case, such as "discharged" or "transferred to another institution." The record itself must be carefully reviewed for order and completeness. In the event that the record is found to be incomplete, an entire process is undertaken for contacting the person or persons responsible, and for following up routinely until it is completed.

Next, the Medical Record Department records information for future analysis and research. The actual procedures used may vary from a very simple recording of a few codes on some cards all the way to extensive use of data processing capabilities. Whatever the method, the procedure involves a knowledge of a classi-

fication scheme for all disease entities and operative procedures. The purpose is to classify records according to each diagnosis, each operative procedure, and according to physicians who rendered the care. This enables the department to assist interested researchers in such projects as tracing patterns in the cause and treatment of disease entities, evaluating the relative effectiveness of different operative procedures, or documenting the professional experience of a physician who is seeking Board status in his specialty.

Finally, the record is ready for filing, but this is by no means the end of the work. Since the whole purpose of maintaining the records is to have them available for the future care of the patient, for providing information to third parties for his benefit, or for medical research, the work of the Medical Record Department continues in order to provide the records when needed. While at first thought you may not think this represents much activity, I might just mention that in a hospital which offers outpatient care and which engages in research, it is not unusual to find that there are more clerks employed in the filing section of the Medical Record Department than in all the other sections combined.

The skills of the medical record librarian and technician must enable them to deal with all of the functions I've just been describing, so let me tell you something about just who these people are, and what kinds of qualifications they have for carrying out their duties.

The Registered Record Librarian (RRL) is the professional member of the medical record personnel team. Registration is achieved by the completion of specific educational requirements and the successful passage of a national qualifying examination given by the American Medical Record Association (formerly known as the American Association of Medical Record Librarians). The educational requirements for the Registered Record Librarian specify graduation from an approved school for medical record librarians, and today these schools are all at the baccalaureate or post-baccalaureate level. The profession has been growing toward this educational level requirement gradually, since the initial establishment of qualifications for registration in 1933. The educational requirements have been elevated as necessary to keep pace with the constantly expanding role for which the professional has had to prepare as the health care services of our nation have become more and more complex. Consequently, the professionals actively working today range in their formal education achievements from high school graduation through attainment of a masters degree.

The role of the professional medical record librarian has traditionally been that of a manager of a medical record department. This role has been expanding in recent years both within the direct care institution and in other directions as well. Inside the hospital, the role of the Registered Record Librarian has expanded to include additional responsibilities in management, data processing, and other activities related to health information systems.² Because of his specialized knowledge, of the uses of patient related information and his experience in working with other health professionals and non-professional health personnel, the registered medical record librarian is frequently called upon to play a leading role in the design, coordination and evaluation of programs being developed for the improved care of the patient.

This same knowledge and experience has contributed to his value as an employee of health agencies, commercial firms, and educational institutions which participate in the delivery of health care.

A very natural outgrowth of this ever increasing demand for the services of professional medical record librarians has been the recognized need for other levels of additional medical record personnel. The development of the Accredited Medical Record Technician (ART) as the technically oriented sub-professional level of medical record personnel has been the result of this need. This classification of an assistant in medical records was formally instituted by the American Medical Record Association in 1953. The criteria for accreditation parallel those for registration in that they consist of completion of formal educational requirements followed by the successful passage of a national qualifying examination given by AMRA. There are a variety of ways for completing the educational requirements, and since these play a role in determining the type of individual whom we are able to attract to this field, I shall come back to this topic for a bit later on.

"The knowledge and skills of accredited record technicians are utilized primarily in small institutions and as supportive personnel to the registered medical record librarian in complex medical centers."³ Since an ART may be the most highly trained medical record employee in a small institution, her functions in such an instance might include the planning, development, and evaluating tasks which would more often be the role of the registered record librarian in the larger institution. In the final analysis, the specific tasks performed by the assistant in medical

²Ibid

³Ibid

records will be determined by his own abilities and level of achievement and by the needs of the institution he serves.

As I mentioned a moment ago, there are different approaches to becoming an ART. The educational requirements may be fulfilled by the completion of a formal scholastic program for medical record technicians. At the present time, there are 19 approved schools in 13 different states. Fifteen of these programs are located in state junior college or state technical school systems, while the remaining 4 are hospital based programs. By September of this year, 13 more junior colleges which are either now in the process of organizing programs or which have students currently enrolled in the first half of their program will be requesting the formal approval of the American Medical Association, the official accrediting body for both ART and RRL schools. The approval of these additional schools will also extend the availability of these programs to 20 states.

The student medical record technician receives training in numerous subjects, so that he will be equipped to either perform alone, or assist in the performance of all of the technical tasks which are the responsibility of the medical record department. A typical two year junior college program concentrates on basic concepts and techniques during the first year, covering such topics as medical terminology, anatomy and physiology, typing and transcription, and beginning medical record science. This latter subject area is itself broad and exposes students to a variety of alternative procedures for carrying out the types of functions I described earlier, for example, the study of two major systems for the classification of diseases and operations.

In addition to these lecture sessions, the student participates in laboratory practice sessions and actual directed practice experience with the techniques being studied. The first year also allows for general liberal arts courses, both as requirements and as electives. During the summer between the two years, the student receives a concentrated period of directed practice in the field, for which course credit is given.

In the second year, the more complicated medical record concepts are taught. This includes such topics as the organization of the medical record department, its role as a service department within the total institution, the legal aspects of medical records and of the release of medical information, and the organization of the medical staff, with emphasis on those medical staff committees which work closely with the records. In this year, the student also continues with his laboratory and directed practice experience and with elective courses as well. Upon completion of the course, the junior college grants an associate degree to the student.

With schools in only 20 states, there is still a long way to go in making this type of collegiate educational opportunity for accredited record technicians available to potential students throughout the country. Not the least of the problems is finding sufficient registered record librarians to meet the staffing needs of the educational institutions wishing to establish programs.

However, there is a second means of meeting the educational requirements for accreditation and this is available even to students in isolated areas. This is the satisfactory completion of a correspondence course offered by the AMRA and accredited by the National Home Study Council. The development of this home study course was made possible by a grant from the W. K. Kellogg Foundation in 1959. According to an AMRA report of 1969, 2665 people had successfully completed the course at that time and an additional 1461 were enrolled. Requirements for admission to the course include high school graduation or its equivalent and employment in a medical record department, the latter because much of the instruction requires access to actual medical records and the opportunity to practice specific technical procedures.

The course material covered is the same as the technical content of the junior college ART curriculum, and the working experience parallels the directed practice experience given to the collegiate student. There are 25 lessons in the course. Each student is assigned a course assistant to whom he mails his lessons and who responds with personal guidance and individual instruction. Twenty-four months are allowed for completion but the average student finishes in less time than this. A certificate of completion is awarded, and the student is then eligible to write the qualifying examination for accreditation.

Having two different avenues for the achievement of eligibility for accreditation has resulted in the ability to attract people from a wide variety of personal circumstances into the field. In preparing for this conference, I reviewed some articles which featured the highest scoring technicians on recent accreditation examinations. I believe these stories are fairly typical of what you would find if you had the opportunity to talk with a group of ART's yourselves.

One recent graduate entered a local junior college following her high school graduation. She anticipated seeking an associate arts degree. At the time that she enrolled, she discovered the newly established medical record technician program and decided it interested her enough to be attractive as her field of study. During the summer between her two years in school, she worked as a coding clerk in a hospital and confirmed her interest in this particular phase of medical record work. Upon

achieving her accreditation, she was employed as a classification clerk in the Social Security Administration.

A young woman with a small child was working in a medical record department to help out the family finances while her husband completed his education. While she was working, it became necessary for the department head to take a leave of absence, and she was asked to assume some supervisory responsibility. She did so, and at the same time enrolled in the correspondence course. Having attained her accreditation, she is now employed as a medical-surgical transcriber and statistical abstract clerk. She hopes some day to go on to achieve registration as a record librarian.

One lady read an article in her home town newspaper concerning jobs available in the health field. Since her children ranged in age from 15-21, she felt able to explore these careers more fully and enrolled in a course in a night program of one of the junior colleges. When she discovered how much she liked her studies, she spoke to the director of the program and made arrangements to transfer to the regular daytime program. Since achieving her accreditation, she has decided to go on and work toward her registration in a four year collegiate program.

Finally, a woman whose children had reached an age where they were now on their own found herself able to go back to school full time. She completed a junior college medical record technician program, and then, since she was free to travel, accepted a position as head of a medical record department in Alaska.

Whatever the personal story, each of these new ART's was qualified to make a specific contribution toward the delivery of health care. I would like to generalize a little in order to give you an idea of how the technician fits into the overall picture which includes all levels of medical record personnel.

First, in association with the Registered Record Librarian. When the two work together, the RRL usually does the planning and the general supervision, while the ART serves as his assistant in the direct day to day supervision of a specific segment of the work, such as the handling of correspondence or of transcription services. In such a role, the ART usually couples supervisory duties with actual production work.

The ART is often the only non-professional person technically equipped to do a particularly complicated portion of the medical record department's work, such as the collection of statistics or the classification of diseases and operations. In such cases, he would be likely to bear the responsibility for the total performance of the function and would work alone, conferring with

the RRL as needed.

Another function which the technician may perform as both a supervisor and a productive worker is that of the review of records for completeness and the extensive followup work required to see that all deficiencies are corrected. This role usually requires maintenance of high standards of performance, constant review of the overall work outstanding, contact with other departments and sometimes some rather delicate handling of the doctors being asked to complete the records.

When an ART performs in any of these roles, he is often called upon to work with personnel of other departments throughout the hospital and with members of the medical staff. He may be seeking their assistance in gathering data or assisting them in the retrieval of that information when it is needed. An ART serving in such a capacity is equipped to work with both the professionals and non-professionals whom he may encounter in the performance of his duties.

To summarize, then, the accredited record technician is prepared to carry out any or all of the technical functions which are the responsibility of the Medical Record Department. Further acknowledgment of this preparation is the fact that he is frequently employed by smaller hospitals to carry the total responsibility of the department. A hospital which uses an ART in this manner often engages an RRL for consultation services to the ART on a regular basis. Such an arrangement provides depth, particularly for such purposes as reviewing the overall operation of the department or planning for the changing needs of the institution.

A question of much concern to all the allied health fields at the moment is that of mobility. Geographic mobility already exists, since our qualifying examinations are national and we are not subject to state licensing. Lateral mobility for a medical record technician, and for that matter for a medical record librarian, is not usual, except where a single portion of the work grows sufficiently to cause it to become a separate department. For example, a small data processing section within the Medical Record Department may grow to such an extent that it is made an independent entity. An ART who had been supervising a section of this type might then be moved with the job but upward mobility is a much more realistic possibility for the Accredited Record Technician.

The American Medical Record Association has been actively encouraging the junior colleges developing technician programs to do so in conjunction with their state colleges which offer training for Medical Record Librarians. Where this kind of co-

operation exists, the technician is able to progress from one program to the other without undue loss of credit or unnecessary repetition of work. The student can then concentrate on the additional medical record course work and the general requirements of the baccalaureate degree program. After listening to the discussions yesterday, I am optimistic about the prospects for mobility in this manner.

In the case of the technician who was educated through the correspondence course though, the matter of progressing toward registration is less simple. I am hopeful that our colleges are becoming both better equipped to evaluate an individual's education level and more willing to recognize educational achievements which have been gained outside of a formal school environment. If this becomes so, the correspondence student will also be able to build upon his fundamental education in order to move up the career ladder.

Whether a medical record technician chooses to progress to registration or to continue employment as a technician, there should be no question of a lack of job opportunity. It seems that as fast as we can train more people, whatever the level, the need for trained people grows at an equal or even greater rate. It seems to me that this circumstance can only serve to strengthen the appreciation of the Accredited Record Technician in the future.

Discussion Workshop

MYRA ENKELIS, RRL, B.A., *Chairman*
MILDRED F. HEAP, LPT, M.S., *Recorder*
THADDEUS SMIEHOROWSKI, *Junior Student in Physical
Therapy, Coordinator*

Educational needs for medical records assistants became the initiating topic for this group and the need for expansion of two year college programs was cited. A real need is being met in the rural areas, in part, by the excellent correspondence courses in medical records. Similar to the two year associate degree programs except for the liberal arts courses, these self-study sequences are filling the void for those unable to attend formal, regularly scheduled academic classes. The success of the associate degree programs leading to certification (ART) was attested to by the citing of the many big jobs taken on by those graduates.

The related issues of transfer credit were aired and there appears to be a great deal of wasted or "repeat" credit time

and it was the consensus of the group that ART could transfer complete transcript if four year programs would offer challenge course credit. The same opportunity should be extended by both two-year and four-year programs to those who have successfully completed correspondence work in Medical Records.

In their discussion of the utilization of personnel, the discussants concurred that job descriptions of all employees must be very clearly stated as must the policies concerning personnel roles. Without these, the myriad of details indigenous to medical records might well go unaccomplished. For example, ART could be responsible for all coding, etc. The RRL, on the other hand, is now facing an ever expanding future of increased responsibilities. One such innovation of staggering proportions is the increasing utilization of computers requiring of the RRL sophistication in all aspects of computer methodology and hardware. It was felt that the differences of function, role, capability, limitations and potential of the ART and the RRL must be known and appreciated by all health care personnel.

Considerations of core curricula in this field were most intensely pursued in frank awareness of basic similarities of interests among medical secretaries, medical records staff personnel and medical officers. This gave rise to the problems of recruitment and of attracting more people to the field.

The Dietetic Assistant

KATHARINE E. MANCHESTER,
Col., AMSC

*Chief, Food Services, Walter Reed Hospital
Washington, D.C.*

For the last several years the American Dietetic Association has had a committee to study the role of the Dietetic Technician

(Assistant Dietitian) as related to the registered Dietitian, the qualified Dietitian (not Registered) and the Hospital Food Service Supervisor.

The Hospital Food Service Supervisor (a member of the Hospital Educational Institution Food Service Society) receives on-the-job-training and educational preparation under the auspices of the American Dietetic Association. The HEIFSS member, the Food Service Supervisor, might better be given the title "Dietetic Aide" since this on-the-job-training or preparation is less than 2 years.

This committee has made a comprehensive task analysis with task list for the qualified Dietitian, the Dietetic Technician, and the Dietetic Aide, and listed designated service in the specialized areas of nutritional care, administration, education and research within the Dietetic Department.

Dr. Kenneth Skaggs of the American Association of Junior Colleges worked with our committee. Taking the task list for the Dietetic Technician, guidelines for the education at the technical level, the essentials brochure for that level, and statement of policy regarding duties and responsibilities were compiled and are now being finalized by the committee for presentation to the Executive Board of the American Dietetic Association. The definitions and the functions for the Registered Dietitian, the Dietitian (ADA member), the Dietetic Technician, Dietetic Supervisor, and the Dietetic worker were defined. At this point in time, the complete job descriptions in the four specialties have not been completed. Needless to say there is still active discussion concerning the functions, role and utilization of the Dietitian Assistant (Dietetic Technician).

Since the American Dietetic Association has recently reviewed the minimum academic requirements for the Dietitian, it seemed appropriate to develop minimum academic requirements for the associate degree in Dietetics to include basic requirements (the core), and two areas of specialization (food service management and nutritional service). Understandings for the Technician listing the activities to be performed during the course of training were prepared both in nutritional care and food service administration.

We wanted to avoid a dead end in occupational movement. Since many dietetic majors start in the Junior Colleges, it was desired that we define courses that could be identified for transfer for the baccalaureate degree.

There will be many problems in starting the program. The professional Dietitian must identify those tasks and functions that can be taught and delegated to the Technician. The Dietitian must learn to delegate so that the Dietetic Technician can assume the responsibility as now envisioned and now being performed

in practice in some hospitals.

When our programs are approved, we hope that all our members will quickly work with their Community Colleges and get the programs started as soon as possible.

This meeting has provided us with the type of stimuli needed to keep the faith and continue the development of the role of the Dietitian Assistant (Dietetic Technician) so needed in our profession to provide the patient with quality nutritional care.

Discussion Workshop

KATHARINE MANCHESTER, Col., AMSC, *Chairman*

RICHARD PASKE, B.A., *Recorder*

DONALD HUBER, *Senior Student in Medical Technology, Coor.*

Under Colonel Manchester's leadership, the group quickly perceived that dietitians are at the crossroads in development of careers within the field giving rise to the basic question: which way to go? There seemed to be some unanimity of feeling that a good starting place would be to outline the tasks of the several kinds of assistants and to more carefully delineate the duties of the dietitians. Additionally, there appears to be a concomitant need for a revision of the requirements for membership certification in the American Dietetic Association. (At present, a person must have a baccalaureate degree in Food Service and have served a one-to-three year apprenticeship.) In this revision the dietitians wondered if provisions should be made for the assistant groups. Should they be certified? Should they be used more in specialty areas such as Food Service Management or Nutritional Care? Or should they be used in all areas, as needed? The group seemed to agree that assistants could make a more significant contribution if used in specialty areas and that certification can come only after these specific roles are defined. One of the discussants, a member of the American Dietetic Association (ADA) indicated that an ADA Committee has described the roles and requirements of the assistants — in basic general terms — in two specialty areas and are about to submit two more. The committee has also outlined a curriculum for the assistants and has drawn up a list of understandings and activities to be performed by each. The committee's recommendations will be presented soon to the general membership.

The recurring question seemed to be that of how much responsibility the dietitians will be willing to delegate to the assistants. At this point, one of the participants asked about the

duties of the dietitian suggesting that these must be delineated before deciding what the assistants will do. The participant, a community college administrator, wondered what sort of curriculum his school might offer to assistants. Examples of a dietitian's functions included prescribing diets for patients with given diagnoses; taking prescribed diets in terms of carbohydrates, protein, etc. and translating these into actual menu items.

The "needs" question was raised and it was learned that while *all* hospitals need and should have them, only about fifty percent of the hospitals are fortunate to have full time services. Others are "making do" with part-time and consultant involvement. Many with associate degrees (two year) are functioning as dietitians. . . large metropolitan hospitals have three or four, and some as many as ten dietitians whereas other large facilities have but a few or none. The roles vary widely and much depends on experience with a great amount of in-service (on-the-job) training going on to plug up the gaps.

With this, the group turned to the question of the importance of the specialties. What are they? Are others to be offered? If so, internship programs ought to be set up to expand beyond the sixty-five now available. It was pointed out that none exist in upstate New York. The ADA Committee referred to earlier is also studying these internship programs with attention to the one-year post-baccalaureate internship, the three-year post-baccalaureate internship, the undergraduate internship and others. The evaluation of these is extremely important to planning for the assistants' practicums.

The group concurred that the youth and freedom of this health profession mark this as an appropriate time to take a strong lead and recommended that the ADA: 1) study the need for accreditation; (2) spell out jobs and requirements; and (3) separate the issues of accreditation from that of membership in ADA.

Health Profession Assistant — Dental Hygienist

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An old Chinese philosopher once said, "He who gazes at the stars is at the mercy of the puddles in the road." This thought came vividly to mind, many times, during the preparation of this paper however, the ideas presented are not presented from the point of selling them but rather for examination of their validity in a climate of debate.

I have chosen to discuss dental hygiene not from the view of a therapeutic artisan performing a limited task on the health team production line but rather from the view of the practitioner who enjoys playing a part in the broader tasks of primary preventive oral health services as they relate to total body health.

Reviewing the milestones that contributed to the establishment of health auxiliaries for dentistry and the research that demonstrates the interrelationship of oral health to total health, one is led to wonder why the oral cavity continues to be singled out for the services of practitioners educated in programs other than those preparing professionals to provide services for other specific parts of the body. Is there really such a difference in the basic knowledge these health professionals need? Or — in the case of dentistry — are we allowing the roots of the past that were steeped in "healing" to choke out the progress of present day research? If this is so, isn't it time to eradicate the roots of a tradition that rightfully belongs only to history? Is it perhaps time to design a core program of basic education for

all health professionals similar in design, only to that suggested for health auxiliaries?

As far back as 1903, Dr. M. L. Rheim made a recommendation to the Stomatology Section of the American Medical Association concerning training and state board requirements for a dental nurse. The American Medical Association commended the idea of having this auxiliary to provide oral prophylaxis and the New York State Dental Society attempted to amend the state dental practice act. The change in this act did not take place, however, until 1916 when the first dental hygiene schools were started in Rochester and New York.

Actually, the birth of the dental hygienist is attributed to the persistent efforts of Dr. Alfred C. Fones to institute early and regular primary preventive oral health services as a means for reducing widespread oral disease. Through his work the dental hygienist became dentistry's first licensed auxiliary and the first oral health program was established in the schools at Bridgeport, Connecticut in 1915. Today, the dental hygienist works in dental office practice as well as in most public health settings providing both primary and secondary oral health services.

One of the issues in dental hygiene education that does have direct relevance to lateral and upward mobility in this career is the anomalous situation of having two educational routes, baccalaureate and associate level to essentially the same professional goal, a license to practice dental hygiene. With the additional intra-oral duties now being delegated to the dental hygienist it is quite possible that two types of licensure will be awarded. One license may provide practitioners the right to conduct restricted functions in restricted social settings and a second license of a different nature may be granted to the practitioner trained in basic and expanded functions in the baccalaureate programs.

The history of dental assisting unfolded with the emergence of dentistry as a profession in the latter part of the nineteenth century. The first assistants were men or boys. The first recorded use of a woman as an assistant was in 1885. Correspondence courses for this auxiliary were established in 1947 with formal educational standards receiving the approval of the American Dental Association in 1960. The dental assistant may be certified but to date her functions in the dental office do not require licensure.

The dental technician has been a part of the team since its inception, however, it was not until 1948 that accreditation requirements for schools in which to prepare this auxiliary were formally approved.

Thus to date, dentistry has three formally educated auxiliaries: the dental hygienist, the dental assistant and the dental

technician. There are about 100,000 dentists, 15,000 dental hygienists, 90,000 dental assistants, 30,000 dental technicians presently providing services to sixty percent of the population. It is evident then that the dental profession is in as tight a manpower squeeze as are all other health professions.

What is presently being attempted to alleviate this program in this health profession?

Workshops and experimental programs have been conducted since 1960 but to date no definite conclusions have been forthcoming. The most recent official activity has been the appointment of an Inter-Agency Task Force Committee by the American Dental Association to set some definite procedures. Whether this will be the answer remains to be seen.

At a recent meeting of the Board of Trustees of the American Dental Hygienists' Association the following approach was suggested for consideration by the Inter-Agency Task Force Committee:

The American Dental Hygienists' Association recognizing its obligation to assist in resolving ten years of discussion on expanded duties for auxiliaries suggests consideration of a "systems approach" to study the problem as a whole. Significant in this approach is not how individual personnel function separately, but how they interact and are integrated into a system for the delivery of oral health services.

The first aspect of the "systems approach" is definition of purpose — in this instance — the design of a system for the delivery of oral health services as a right for all people.

The second aspect is function analysis—what has to be done and how. To allow for free, unrestricted speculation about these functions, the question, "done by whom" should not be considered until all functions necessary to fulfillment of the purpose have been identified.

The third aspect is component analysis — who has the potential to do exactly what in fulfillment of the purpose.

Subsequent to identification of these factors curriculums can be designed which would prepare each of identified categories of personnel to competently assume the identified and assigned functions.

It was thought that development of a plan such as this might provide an approach to directed study at the state level, the result of which, when compiled by the Inter-Agency Committee would be generally acceptable to the health professionals, the auxiliaries and the public.

Though written with tongue in cheek, the thoughts provoked by Dr. Peter's book "The Peter Principle" may well be worth considering as we study the problem of preparing health auxiliaries and I therefore conclude with the following two quotes:

Under pressure to get more engineers, scientists, priests, teachers, automobiles, apples, spacemen or what not, and to get them faster, the standards of acceptance necessarily sink: Hierarchical regression sets in. Man cannot achieve his greatest fulfillment through seeking quantity

for quantity's sake: he will achieve it through improving the quality of life, in other words, through avoiding incompetence.

Discussion Workshop

PATRICIA McLEAN, RDH, M.S., *Chairman*

CARL ANDERSON, LPT, M.S., *Recorder*

WILLIAM SCHOETZ, *Senior Student in Physical Therapy, Coor.*

This group elected to discuss the problems of dentistry's auxiliaries as they related to the issues posed during the opening session of the workshop, the first of which was mobility or immobility. It was found that the three presently recognized auxiliaries in dentistry, the dental assistant, the dental hygienist and the dental technician do have limited opportunity for horizontal and vertical mobility. Horizontal mobility was noted in several first year college level health science programs, from which students may progress in vertical fashion to dental assisting, dental technology, dental hygiene, and eventually to dentistry. Information regarding these programs may be obtained from the Council on Dental Education of the American Dental Association, 211 East Chicago Avenue, Chicago, Illinois, 60611.

Discussion of the second topic, "The Assistant's Basic Education," was one of considerable interest to this group. Utilization of the "systems approach" in the design of instructional programs for all members of the dental health team was judged the most appropriate method through which to design these programs. It was hoped that through such an approach, working together, leaders of each group would discuss the system as a whole — not its parts separately, thus to plan, design, develop and manage a new approach to the delivery of oral health services as a right for all. The group emphasized the fact that the most significant factor in this approach is not how the individual functions separately but how all interact and are integrated into the system for the purpose of achieving the goal. An excellent example of one part of a systems approach to curriculum development, i.e. task analysis, can be found in the document published by the Department of Health, Education and Welfare titled: "Guidelines for a Dental Assisting Curriculum."

In discussion of "The Need: Who? When? Where?" it was noted that the prevalence of dental disease is nearly universal; that by age two, 50 percent of the children have decayed teeth; that by age fifteen, the average child has 11 decayed or filled teeth but that these percentages decline about 60 percent in areas where the drinking water is fluoridated. In addition the

group stated sixty to eighty percent of our children have some degree of gingivitis; practically all people over forty have some degree of periodontal disease and nearly twenty million adults in the United States are edentulous because of this disease.

Since the dental population is not expected to increase in proportion to the projected increase in the child population and the anticipated increase in demand for oral health services, this group believed the dentist would have to begin to delegate functions in a manner similar to that of the physician. Many functions presently being offered by the dentist could be provided by dentistry's three presently under-utilized auxiliaries. A suggestion was made that perhaps, working together, the dental assistant and the dental hygienist could render a program of primary preventive oral health services that would substantially increase the oral health of the public.

During the discussion related to licensure and certification it was noted that of the 799 licensed occupations in this country only one group, the dental hygienist, is completely controlled by another group, i.e. dentistry. The group questioned the legality of this point and decided this was an issue requiring further study. It was noted that licensure for the dental hygienist requires graduation from an accredited two year college level program of study, National Board written examinations, and State Board clinical examinations. Whereas, certification for the dental assistant now requires training in a formal accredited educational program and a passing grade on the comprehensive examination provided by the American Dental Assistants Certification Board. The value of certification versus licensure was discussed and the group concluded both were necessary and vital to the improved oral health of the public. It was further agreed that continuing education should be a requirement for maintaining both licensure and certification.

This group concluded that dentistry's presently recognized auxiliaries, the dental assistant, the dental hygienist and the dental technician are *under* utilized and that full utilization of this manpower potential will depend on the ability of these auxiliaries and the dental profession to meet necessary changes before the society, of which they are a part, compels them to do so.

Allied Health Professions Assistants

The Assistant – Mobile or Immobile?

The Assistant's Basic Education

The Need – Who? When? Where?

Certification & Licensure: Blessing or Boondoggle?

MARJORIE TOLAN, RT

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The very title of this conference provides a challenge. I'm not certain that the challenge is the same to each of the health related disciplines here. I know it represented a dilemma to me: how to present the posture of my particular technology that at the moment resists an assistant level, and simultaneously welcomes the opportunity to participate in and cooperate with all health related professions. We have a common, prime goal – the welfare of the patient. Our mutual understanding is critical to that welfare. In conference we deliberate and concur this is critical. But on line – in the hospitals and clinics or wherever large numbers of allied health personnel of separate disciplines seek to satisfy the needs of the patients and the demands of the physician, we seem to be in some sort of tug-of-war contest with the patient the hapless victim of our struggle. It would be well if we were indeed a unified team before we identify more and more careers to further the struggle.

Radiology is the medical specialty dealing with the clinical application of ionizing radiations for diagnostic and therapeutic purposes. It has grown from the humble and hazardous discovery of x-ray in 1895 to the beneficial and hazardous profession now subdivided into diagnostic radiology, therapeutic radiology (or radiation therapy), and nuclear medicine. Our technology has proliferated to meet the needs of the various facets of radiology. Thus, the generic term, radiologic technologist, to encompass x-ray, radiation therapy, and nuclear medicine technology.

Our training programs in each of the categories are based on

the minimum educational requirements to produce qualified radiologic technologists with upward and lateral mobility. We are engaged in the applications of radiations potentially hazardous to the patient, as well as to ourselves.

In review of the technological advances in design and manufacture of x-ray equipment, increased information about the hazards of radiation and the necessity for adequate protection for patient and personnel, any diminution of this *basic, minimum* education would simply exploit the consumer's confidence in the integrity of the medical profession (whether it be hospital, clinic, physician office or the radiologist himself).

From the beginning of establishment of standards of training in 1920 to the present, we have moved toward the firm establishment of this *basic minimum* standard of training. We have proposed and implemented an integration of formal and technical education (both at the associate and baccalaureate degree level) as a means of providing teaching, administrative and research technologists. We do not endorse the dilution of either formal education or technical capability as an expedient. We have modest successes in implementing the promise that technical training can be preliminary to, and credit toward, formal education leading to a baccalaureate degree.

We are providing upward mobility not only through experience and innate talents, but through academic programs. We provide mobility through curricula designed to meet not only the requirements of the baccalaureate programs, but acceptable to graduate programs in hospital administration, Public Health Service, Radiological Health, and Health Physics. While these graduate programs represent loss to our discipline, we believe this channeling of talent at least contributory to the manpower needs of health care.

Perhaps a review of what we have for a base would be of help in understanding our reluctance to endorse the assistant level. In 10 years we have grown 456 AMA approved programs to 1,270 (40 AA programs, 11 BS programs); from a possible yearly enrollment of 3,600 to 15,000; a possible yearly graduation rate of 1,800 to 7,500. In 1968-69 we graduated slightly less than 5,000.

It is proposed that by 1975 we will need 52,000 qualified technologists. We now certify nearly enough to meet the need, but assuredly if emphasis was placed on implementing what we have — filling the programs to a capacity — we would more nearly match manpower needs than if we divert our efforts to other career development. Funding from the federal government has been directed to the University and Junior College programs — or less than 1/20 of our manpower resources. 19/20's is being jeopardized by overemphasis on levels urgently needed, but in

far less quantity.

With basic, minimum standards hardly established, schools inadequately reviewed and inspected, we are almost overwhelmed trying to protect our rear from those who do indeed seek a lesser category.

We are drawn into a maelstrom of debate over terminology. Innocently enough, and with confirmation of proper semantics by dint of Webster's, we have a title that is derived quite appropriately. If indeed we practice the technology related to radiology, it is not fatuous to call the practitioner a radiologic technologist. While this title was separately developed and approved, many of the allied health programs, based on baccalaureate achievement, splintered into programs requiring less training and education, and to differentiate between the degree and non-degree practitioner they were termed technicians. The controversy does not bother the well established technologist, but patronizing reference from other disciplines does detract from our recruitment. Despite varying levels of education, we do not have conflicts within the field because all are included in the generic term of technologist.

We concur with the need for aides or assistants, but where budget allocations and administrative policy allow, they are employed for ancillary tasks specific to the needs of the respective departments:

- dark room assistants;

- personnel to assist patients to and from as well as within the department;

- personnel for tasks ancillary to the production of radiographs such as assistance in heavily populated radiographic areas (chest or orthopedic rooms);

- preparation of barium and maintenance of supplies; etc.

The functions do not lend themselves to uniform training, no matter how limited. We are fortunate that nursing attendants or aides can function readily in these tasks where the fiscal operation permits.

We do not argue the sensibility or need for the establishment of lesser categories for nursing, or medical technology, or physical therapy. But these professions have been built on degree programs and concede the suitability of delegating tasks to non-academic oriented personnel. While recognizing the need for constant reevaluation of methods and environments for training (shooting a few sacred cows along the way) we contend the 24 months program is the *basic minimum*.

A review of statistics is an exercise in futility. We prefer to stay away from numbers. Instead, we prefer to agree with the Council on Medical Education of AMA, as reported by Dr. Warren G. Ball, Assistant Director of the Department of Allied Medical Professions of AMA, who stated that "instead of saying

we need so many thousand more physicians, nurses, and other types of health personnel, the Council feels it more accurate to say we have a shortage of health services. This isn't just an arbitrary distinction, but a rather important one. It is extremely difficult, perhaps almost meaningless, to say we need so many additional specific kinds of people when we're not even sure that the people we have now are being used to the best advantage in meeting health needs. The AMA is concerned with accelerating the production of health workers and making maximum effective use of the people and resources now available.

"There is a need to expand the educational output of the allied health professions through grouping of their curriculum under a medical center umbrella; perhaps in a school of allied health sciences."

So to these points from our point of view:

- (1) Accelerating the production of radiologic technologists: we can provide sufficient quantities of technologists even to the extrapolated numbers proposed by various agencies, only by implementing what we have. The enrollment would increase if there were sufficient economic stimuli with traineeships and graduate salaries; attrition of the qualified technologist would decrease similarly. If indeed a lesser category is established, the financial status of the technologist, already the lowest in the field, would decrease and what is now a concern for manpower would become a bona fide critical shortage.
- (2) Maximum effective use of people and resources: There are many stringent and urgent efforts being made in this direction: Computer aided diagnosis; Image Scanning; Reporting; Automation of storage and retrieval of records; Mathematical models of depts; Automated Scheduling; Automated Billing; Automated statistical data and analysis — (I used to run when a radiologist called; I now jump and run when a CRT 2240 is down or the 1053 printer stops.) These innovations have required the stimuli of people like Lee Lusted of Chicago and G. S. Lodwick of Missouri, Inger Brolin of Sweden, and P. Reichertz of Germany; — they have been augmented by information thru the NASA program, federal funds, multidisciplinary efforts with Engineering, Mathematics, Physics — yes, even radiologic technology. But there is every reason to believe we can reduce radiologist and technologist time from some of the necessary, but nitty gritty chores, to more critical pursuits. This hardly answers the problem of the physician office or clinic, more particularly in the non-urban areas, but it may ultimately reduce the number of technologists needed in the hospitals and in the economic burden to the hospital patient.

- (3) Expand the educational output of the allied health professions through grouping of their curriculum under one umbrella. The example here at SUNY is manifest evidence of the trend in health education.

The autonomy long enjoyed by each health profession, usually under the aegis (if not the thumb) of a specialty of medicine, does not lend itself to economy or efficiency. The example set by University programs could be accomplished in hospital based programs. We should seek a multidisciplinary approach regardless of environment — hospital or academic.

Mr. Detmer¹ proposed that general skills in handling patients might make the allied Health Assistant amenable to several disciplines without the obvious duplication of effort (and expense) of developing cadres of workers for each discipline. (We concur!)

Dr. Perry² posed the thought that there is a predilection for developing curriculum for new careers prior to defining what the product is to be. Job analysis and job description should precede initiation of curriculum. (We have done so.) He also raised the issue of equivalency testing to provide advanced student rating for the trained, experienced health worker seeking advancement through academic achievement. (We are doing so.)

Dr. Endicott³ warned against licensure that would inhibit mobility of the discipline and flexibility of the educational standards. (We concur!) Also he warned against limited training as a stopgap for manpower shortages that would ultimately create more problems (require more curricula, more instructors, more supervisors, perhaps more terminal careers). (We agree!)

It would be foolish for me to try and say it better. We have and will try to meet the challenge of manpower needs, educational advancement, and team effort. All are directed to improved health care.

¹L. M. Detmer, Director, Bureau of Health Manpower, American Hospital Association, Chicago, Illinois.

²J. Warren Perry, Ph.D., Dean and Professor, Health Sciences Administration, State University of New York, Buffalo, New York

³Kenneth M. Endicott, M.D., Director, Bureau of Health Professions Education and Manpower Training National Institutes of Health.

Discussion Workshop

MARJORIE TOLAN, RT, *Chairman*

EDITH MAYERSON, OTR, B.S., *Recorder*

JAMES MORSE, *Student in Occupational Therapy, Coordinator*

The main topics of discussion were the relationship of the American Medical Association to The American Society of Radiologic Technologists. The latter has provided input to AMA through the American College of Radiology. The relationship of ASRT, thereby, to the problems of standards that will prove equitable for the 24-month hospital based program, baccalaureate programs and junior college programs is integrated not only with the tedious routing of proposed changes, but with legislative requirements existing and pending.

While the physician (and in this profession, the radiologist) has the ultimate responsibility for patient care, technologists and ASRT representing them, believe it appropriate that the physician serve as advisor in the establishment of standards of education and training of technologists. At present, the physician predominates not only in educational policy decisions, but in certification criteria as well.

The increasing number of Junior College programs, with the incumbent necessity of blending varying academic requirements with clinical practicum necessary, has had priority attention from both the Society and the American College of Radiology.

The traditional on-the-job training, with little didactic requirements, precipitated the trend for student stipends. And though the twenty-four month programs are now didactic oriented in principle, if not in fact, stipends remain the prerogative of the individual institution. On direct inquiry as to her personal opinion, Mrs. Tolan stated opposition to stipends. This view is in the frame of reference to the bilateral program at the University of Missouri, both baccalaureate and twenty-four month respectively. Emphasis on education should not be diluted, nor offer a means of exploitation of students as cheap labor, by payment for the supervised clinical practicum involved in producing quality technologists.

In reference to legislation for Radiologic Technologists: the ASRT has favored federal regulation for the establishment of standards of training predicated on the protection of the public. Opposition to state licensure has been based on concern for varying standards established for fifty states, limitation of technologist mobility and lack of flexibility for revisions in a dy-

namic, many-faceted technology (x-ray, nuclear medicine, and radiation therapy). The ASRT is urgently seeking federally regulated standards based on the established, but minimum, standards now predominantly voluntary.

The Occupational Therapy Assistant's Role in the Practice of Occupational Therapy

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Historical Development of Training Standards for Occupational Therapy Assistants

In 1958 the American Occupational Therapy Association established standards for training and recognition of occupational therapy assistants in psychiatry. At that time the general consensus was that assistants should be trained in one specialty area and that a training program consisting of no less than 12 consecutive weeks (430 clock hours) would adequately meet training objectives. It was generally expected that these programs would be in-service in nature and hospital based.

Two years later, standards for training occupational therapy assistants in general practice were established. It is interesting to note that the first program in this area was concerned with training personnel, at the sub-professional level, to assist with the implementation of occupational therapy services for geria-

tric and other long term care patients. The duration of the general practice program was similar to that for the psychiatric training program.

In 1963 the American Occupational Therapy Association's next step was to develop standards for combined training programs designed to prepare the trainee to assist with the implementation of occupational therapy programs in either psychiatry or general practice. The duration of these programs could be no less than 20 consecutive weeks and required a minimum of 750 clock hours consisting of didactic instruction; skills instruction; clinical practice and evaluation.

It should be noted that the training programs hitherto described were of a terminal nature since academic credits were not provided.

The continuing shortage of professionally trained occupational therapists coupled with increasing demands for occupational therapy services prompted the American Occupational Therapy Association to embark upon pilot programs for trained assistants in junior college and community college settings. This move is particularly significant in that it enables interested graduates to move upward into baccalaureate degree programs in occupational therapy, and thus become professionally qualified occupational therapists.

Certification of the Occupational Therapy Assistant

Graduation from any of the training programs described, qualifies the assistant for certification with the American Occupational Therapy Association provided the program has been approved by the Association. It maintains an annual directory of Certified Occupational Therapy Assistants (COTA's as they are commonly called) who are in good standing with the Association. The level of training completed by these individuals ranges from the 430 clock hour one speciality (non-academic credit) program to the Junior College or Community College Associate Degree Course. The disparity of these programs has brought about a problem which will be discussed a little later in this presentation.

Functions of the Occupational Therapy Assistant

Theoretically, the functions of occupational therapy assistants, as contained in the American Occupational Therapy Association's standards are categorized as follows:

1. General Activity Programs

These are primarily designed to increase or maintain the patient's morale and are used to fulfill his normal needs. The occupational therapy assistant is considered qualified

to conduct such programs with minimal guidance from the professionally qualified occupational therapist.

2. Supportive — Maintenance Programs

These programs are designed to enable patients to maintain their optimal level of function and the gains resulting from specific treatment. The occupational therapy assistant is considered qualified to carry out these programs under the guidance of the professionally qualified occupational therapist.

3. Specific Treatment Programs

These programs are designed to correct or improve specific pathology. In specific treatment the occupational therapy assistant functions only as an assistant to and under the direct supervision of the professionally qualified occupational therapist.

Occupational Therapy Assistants are Currently Employed in:

1. Psychiatric hospitals
2. Facilities for the mentally retarded
3. Nursing homes and Extended Care Facilities
4. Non-psychiatric hospitals
5. Rehabilitation Centers
6. Home Health Agencies

The functions of the occupational therapy assistant will vary in accordance with the type of facility in which he is employed.

The report of a study conducted by Margaret Adamson and Mary Alice Anderson concerning the utilization of occupational therapy assistants was published in the March - April, 1966 issue of the American Journal of Occupational Therapy. The facilities surveyed by questionnaire represented a cross sectional sample of occupational therapy departments treating psychiatric and physical dysfunctions throughout the United States.

Questionnaires were mailed to 75 facilities treating psychiatric patients, and to 76 facilities treating patients with physical dysfunctions. One hundred of the 151 questionnaires were returned. Forty-nine of the responses came from psychiatric facilities and 51 completed questionnaires were returned by facilities treating patients with physical dysfunction.

The respondents indicated that significant use was made of assistants to carry out general activity, supportive maintenance, and specific treatment programs which were set up by professionally qualified occupational therapists. The question "Do you think occupational therapy assistants can alleviate the growing problem of the shortage of registered occupational therapists?" was included in the questionnaire. Ninety percent of the respondents gave a "yes" reply. This indicated strong endorsement of the use of trained assistants.

To further test the reactions of the registered occupational therapists, the following question was asked: "If further training and certification were available, what changes would you anticipate in the duties of your assistants?" In the area of psychiatry over half of the centers replying to this question believed their assistants had received maximum training, hence did not foresee any changes in duties.

Occupational therapists representing departments concerned with the treatment of physical dysfunction indicated that if further training and certification were available, they would assign treatment planning responsibilities to the certified occupational therapy assistant.

Generally speaking, it may be concluded that many registered occupational therapists recognize the need for trained occupational therapy assistants and that their use can alleviate many of the problems created by the shortage of professionally trained occupational therapists. However it is not uncommon to hear, "I couldn't get a registered therapist, so I had to employ a certified assistant." When an assistant is hired in lieu of a registered therapist, he may find himself expected to take on responsibilities beyond his level of training. This creates complications particularly in a facility which employs only one registered occupational therapist; if the professionally trained therapist resigns his position and a qualified professional is not employed in his stead. For example, both Medicare's Conditions of Participation and the New York State Hospital Code stipulate that occupational therapy treatment must be given and supervised by a professionally qualified occupational therapist. This means that a facility staffed only by Certified Occupational Therapy Assistants is not in compliance with these standards, hence is not eligible for either Medicare or Medicaid reimbursement for occupational therapy treatment services.

Problems

1. Development of reasonably uniform job specifications for occupational therapy assistants;

In my capacity as a State Health Department Consultant, I find myself constantly confronted with the problem of trying to provide guidance to local civil service departments that are attempting to develop uniform job specifications and classifications for occupational therapy assistants' positions. How do you go about equating the qualifications of a Certified Occupational Therapy Assistant who has completed a 3 months', non-credit one speciality training program with those of the Certified Occupational Therapy Assistant who is a graduate of a junior college or a community college program? Should the first occupational therapy assistant be accorded the same salary level as the junior or community college graduate? Can you consider him qualified to assume the same level of responsibility as the Associate degree graduate?

2. Clarification of the nature and degree of supervision which should be provided by the registered occupational therapist:

Let me share with you other questions constantly asked. "What is meant by *direct* supervision? If the occupational therapy assistant is utilizing a specific treatment procedure for a particular patient, is the physical presence of the registered occupational therapist in the treatment area required?"

These questions are posed by personnel responsible for making decisions concerning reimbursement for occupational therapy treatment provided to Medicare and Medicaid patients.

It behooves occupational therapy to establish realistic guidelines regarding supervision of the occupational therapy assistant which will be in accordance with federal (Medicare) and state standards.

I share these problems with you in the hope that they may be considered for discussion during the afternoon workshops. I would be very much interested to know if any of the other disciplines represented here are faced with similar dilemmas and if so, what steps are being taken to resolve them.

Discussion Workshop

M. ARLENE MELLINGER, OTR, *Chairman*
JUDITH STEINBERG, OTR, B.S., *Recorder*
MICHELE MORDANT, *Senior Student in Occupational Therapy, Coordinator*

The discussion began with an explanation of the existing programs for Certified Occupational Therapy Assistants. The three

most prevalent types are:

1. Hospital Based programs.
2. One-year community college programs.
3. Two-year community college programs (AA degree).

The community college programs are flexible in that students may attend on a part-time basis. In such cases he may take three or four years to complete the course. The one-specialty programs designed for psychiatry or physical disabilities are phasing out, as the comprehensive programs, including both aspects are more realistic.

In order to be certified, an assistant must:

1. Be a graduate of a course approved by the American Occupational Therapy Association.
2. Renew his certification with the American Occupational Therapy Association on an annual basis.

Questions concerning whether a person is certified, "under the grandfather clause" can be directed to the American Occupational Therapy Association.

Hospital and nursing home administrators have difficulty trying to determine salary and grade level for the COTA in view of the varying types of training programs. An assistant's line item usually does not exist per se. Administrators usually determine salary and grade level for any type position according to years of academic training required. The COTA's range from 0 to 2 years academic training, some having an AA degree and others no degree. However, all may be certified as Occupational Therapy Assistants, provided the program completed has been approved by the American Occupational Therapy Association.

The question was then asked if any of the occupational therapists in the workshop were using COTA's and if so, in what capacity? A few therapists did work with assistants primarily in nursing homes. One therapist working with a COTA in a physical disability setting described her relationship with the assistant. Both would sit down periodically and discuss the role of an assistant and therapist in their setting and how they together could offer optimum patient care.

A few comments were made concerning direct supervision of the certified Occupational Therapy Assistant. There was no verbal disagreement among the group when it was stated that direct supervision does not mean that the OTR is always physically available. It means that the OTR evaluates the patient, plans the treatment program and does re-evaluation. The assistant carries out the program with as much OTR supervision as required.

A more lengthy discussion followed concerning the four-year (BS degree) occupational therapy student dropout and whether he could be somehow put on an assistant's level. It was agreed that schools have a somewhat diversified curriculum and much depends on the school and the year in which the student decides to drop out, as to whether he would, in fact, qualify as a certified assistant. In such cases, it is advisable for the student to check into his eligibility for qualification as a COTA. A participant from the Office of Allied Health Manpower under the State Health Department stated that if the dropout was due to financial reasons the State had a program which would finance a hospital employee who wanted to go to school on a parttime basis while working at the hospital in order to complete his technical or professional education in occupational therapy.

The practicality of general "common core" curricula for assistants was then brought up. A general curriculum geared to train assistants to work either in occupational therapy, physical therapy, or other allied health fields had been tried. It was found that graduates of such programs had no sense of identification with any profession. A more realistic program seemed to be the one in which all students were enrolled in a core curriculum for the first year of their training with an enrollment in their chosen specialty during the second year. This would not be a dead-end program as the student could change specialties and still maintain the first year credits. One reason this design is favored is that it is believed that different people perform different functions better and that there are basically different people in each professional group.

The next issue posed a challenge to the group as to whether the OTR's are really backing the COTA's especially concerning salary in order to keep good assistants in the field. Salaries seem to vary so greatly that an assistant in some parts of the country makes as much money as a registered therapist in another part of the country.

The final point discussed was the definition of occupational therapy as a profession in view of the broad scope of services it provides.

The Role of The Physical Therapy Assistant in The Delivery of Health Care

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As an initial comment, I would like to commend the planning groups' selection of the Conference title, "Allied Health Professionals Assistants." Initially, I recollect using the general term "non-professional", however, due to the demeaning nature of this term, we selected the broader classification "supportive personnel." Concern has been raised by many that this term is too general and does not clearly indicate who this individual will be supporting. Since we have observed extensive abuse to physical therapy practice through the utilization of unqualified individuals, fear has further been enhanced by this new general title. The Conference has narrowed the interpretation and it can be further defined by the various professions as meaning the physical therapist's assistant, the occupational therapist's assistant, and so forth.

Utilization of personnel to support our efforts is really not new to us, the physical therapist. As direct providers of service, we have utilized aides, trained and supervised in our departments, lay volunteers, immediate members of families, and even the patients themselves. However, it has been recognized not only by our profession, but by the health team and the consumer that this particular approach has been ineffective in meeting the increasing demands for our service. I must disagree with much of

the literature in their impression that we, as a profession, were the prime movers in bringing change to the delivery of physical therapy services. Quite contrary, I feel it was certain external forces which brought pressure on the profession to accept the fact that we must find additional methods to increase the supply of our service. It is quite probable that the changing patterns of care were initiated in the early stages of the development of the Civil Rights Program of the fifties, so one can easily see the length of time needed to implement change. The Health Professions Act of 1963 and the Allied Health Professions Training Act of 1966, were reinforced by the Comprehensive Health Planning Act in bringing increased pressure on the need for change. One certainly does not need to look too far or think too deeply to recognize that in the 20th century our nation is in the grip of intense change. There is no reason to believe that the social and cultural influences acting on our nation would not affect our health delivery system. It has been stated before, and I shall state it again, "We have no choice, but to accept that change is a part of our lives today."

I feel that in order to effectively be involved in a pattern of change, one must recognize the various factors influencing change. The social and cultural pressures of our times are demanding a total re-structuring of our delivery system. Society no longer looks at health care as a privilege, but accepts it as an acknowledged right. In a recent report of the Health Task Force of the Urban Coalition, they state: . . . "From the beginning, we have come to grips with two major myths. First, is the myth that medical care in the United States is the best in the world for the majority of people. The other myth is that the poor and rich get the best medical care. The facts point otherwise. Health services for poor people are episodic, fragmented, often humiliating, and in many instances, unavailable or inaccessible. The tax funds go to the provider — doctors, pharmacists, hospitals, for services they charge for, and there are no guarantees of the quality of service rendered. The disorganization of health services is not the special problem of the poor. It is only more widespread, more obstructive, and more readily visible among the poor."

There are a number of factors which are exerting pressure on our present system and leading, therefore, to the difficulties within the system:

1. A continued population expansion showing greater numbers of both young and old.
2. Greater public awareness of health, coupled with demand that the services be accessible and available.

3. An expansion of our scientific knowledge in the area of health care.
4. A trend towards increased specialization — which leads to fragmentation.
5. Increasing cost of health care and the concern of the consumer — the third party payer.
6. The high cost of preparing specialized workers.
7. The fact that most of our specialized workers are over-trained for most segments of our health delivery system.

I would also like to project the thesis that as a nation we were in need of new technical jobs for the unemployed in our continued population expansion. This need, coupled with the void in health service manpower was an appropriate source of relief, and most probably one of the reasons why we have seen such intense legislative activity in all of these areas during the past few years. In essence, this approach has met two needs of our nation.

Before I proceed any further, I would like to briefly allude to the area of educational preparation for the physical therapy assistant, pointing out that this preparation has shown a variation from our previously accepted procedure of training the technical worker in the hospital. The educational preparation of the assistant has now shifted to the educational setting, in order to insure a higher level of educational standards, as well as vertical and horizontal mobility within the educational system, instead of the traditional dead end found in most vocationally oriented programs. However, this particular area of upward mobility might even be questioned at this point, as has been indicated in a study by the National Committee on Employment of Youth. We should also be cognizant of the fact that pressures are also being brought to bear on this particular approach, due to the fact that it also creates a system whereby there is no "upward mobility" for the individual working in the categories below, such as the aide. One question that might be discussed here today is the feeling by many that a student should be given credits for time spent as an aide, and just how could an aide become a physical therapy assistant and conversely, how could a physical therapy assistant become a professional physical therapist, based primarily on experience?

Florence Cronwell, Past President of the American Occupational Therapy Association, stated, "We are now at the verge of a new era when the needs for our services are so great as to push us to the brink of glory, if we can only deliver, but we may stumble because we shall, I fear, cling tenaciously to what we have done without looking at what we might do if we were

able to take bold new directions." (1) I do not feel that it is inappropriate for the professional physical therapist to question his role or the role of this new work category in our projected delivery system. However, I do feel we must not be held to the activities which have, in essence, developed out of tradition and are supported in the mystic which surrounds the services we are providing. It is interesting in reading, to note how many times individuals or institutions often support change, but only in light of the fact that it does not affect them directly. In this light, there is nothing that disturbs me more than the planner who has lost touch, not only with the services being provided, but also with the consumer of these services, and therefore looks to the delivery of services as a purely theoretic model. In some instances, I feel these pressures are being applied to the change in our delivery service, and as professionals, we must be greatly involved in the planning to insure a truly appropriate physical therapy delivery system.

I have always felt proud to be a member of the physical therapy profession, since I have always felt that as professionals we have been able to look quite objectively to the needs of the patients we serve. In projecting our role into the future, I see no appreciable change in this basic philosophy, but only a division of responsibilities in the application of services we provide. I join the chorus of individuals who advocate the theory that this new level of supportive personnel will not take our jobs away from us. However, this realignment of responsibilities might cause us to relinquish many of the tasks we have done traditionally. Since many of these tasks involve the repetitive activities within our profession, we will also see a definitive reduction in the direct patient contact we have come to cherish so highly.

Since this particular change necessitates a deviation from many of the basic motivations and drives which brought us into the profession of physical therapy, one will need to recognize and accept these changes if he is to work in the new delivery system. As a profession, we will also need to change our methods of recruitment.

Practically, the classic structure of health delivery in our country is a pyramidal structure. The pressures for change being applied to our profession are also being exerted against this particular structure, and all indications are that if any individual segment of health care is to be realigned, the total structure is also going to have to make similar adjustments. Looking at this area realistically, I would judge that legislative activity will again have to be the prime factor in bringing about this change. Eli

Ginsberg stated the underlying basis to the problem: "The most serious barrier to the effective manpower utilization in the health field is the fact that each group is not strong enough to fight successfully against the group which is higher on the ladder and which spends most of its energy preventing those below from moving up." (7) To me, this "upward mobility" within the structure of health care is going to be one of the most crucial factors in the success or failure in the re-structuring of our system. This relates not only to the physical therapy assistant, but also to the professional physical therapist himself and exactly how he is allowed to assume additional responsibilities in the area of management and decision making from the level which lies directly above us in this pyramidal structure. I have seen no actions in the past few years to make me feel that those above us in this pyramidal structure are willing to accept and recognize the need for sharing of responsibilities. Contrary to the entire philosophy of sharing of responsibilities, we have seen pressures from certain segments of the medical profession for them to assume many of the decision making responsibilities relating to physical therapy, which heretofore had been the responsibility of the professional physical therapist.

Before we consider discussion of the role of the allied health professional assistants, we must also take into consideration a charge given to us by the consumer of our services that the new delivery system creates a high quality program. Many individuals view the development of supportive personnel in health care as a strict increase in quantity of services being made available to the consumer with little attention being given to the quality. I strongly feel this is where our profession must play a primary role in the development of these new services to insure quality.

I believe our professional Association — the American Physical Therapy Association — has recognized and assumed this responsibility through the 1967 policy statement on the physical therapy assistant. Subsequent to that meeting, the Association, through its Committee on Supportive Personnel, has prepared numerous documents to insure proper development of the physical therapy assistant through the development of criteria for educational and clinical facilities, standards and curriculum guidelines, accreditation procedures, and recommended job descriptions for the physical therapy assistant. I would like to allude to the fact that there is going to have to be a certain amount of flexibility allowed in the development of job descriptions for the physical therapy assistant, but again keeping in mind, that if we are to consider quality care, these responsibilities must be commensurate with the assistant's background and experience.

For years, everyone assumed that good intentions alone would guarantee quality care. However, I am sure everyone here would agree that quality care is extremely difficult to define, let alone to evaluate it. Those concerned with this particular area have been able to draw together various factors which they feel lead to quality care, and we certainly will hear more on this subject in the years ahead. Helen Blood, in a paper given by her relating to the topic under discussion today (5), advanced the philosophy that in order to truly understand the meaning of quality, one must develop some type of a conceptual framework before they can begin to be specific. She further indicated that Dr. Malcolm Watts, in the 1967 National Health Forum on Quality Care, identified six parameters in such a conceptual model.

"The first parameter, *competence*, refers to scientific and psychological adequacy of judgment and the skill and capability to utilize currently available knowledge in health care.

The second, *availability*, refers to the extent to which a resource for health care is accessible or obtainable at the time, place, and in the amount needed.

The third, *motivation*, refers to the drive or incentive to receive, render, or otherwise provide health care services of high quality.

The fourth, *effectiveness*, refers to the extent to which the aim or purpose is accomplishing its prevention, diagnosis, treatment, rehabilitation, health maintenance, or any other aspects of health care.

The next, *efficiency*, refers to the performance in the sense of producing the desired results with a minimum of expenditure for waste of talent, time, money or materials.

The last, *satisfaction*, refers to fulfillment of reasonable expectations of those who receive, render, or otherwise provide for health care. Based on these concepts, he suggests "that high quality medical care is

- (1) up-to-date from the standpoint of scientific knowledge and technology,
- (2) available without significant variation because of geographic, economic or political situations to those who need it,
- (3) embodies a high degree of motivation on the part of the patient, the physician, the health care team and those responsible for the equipment and facilities, community and the regional services and the health care programs and plans, as well as those responsible for the financing." (5)

The dimension of quality must be an overriding element as we consider every facet of job analysis in determining the role for the physical therapy assistant. Recognizing that time and patient-therapist ratios are important elements in the determining of quality, the professional physical therapist, as the individual who will be delegating responsibility within the physical therapy service, will have a very important role in determining and maintaining quality.

In considering the role of the physical therapy assistant, I have indicated that we need both a job and task analysis within physical therapy. Projecting the fact that the physical therapy assistant works within the physical therapy service, under the direction of a physical therapist, I would like to first consider and share with you a general outline of responsibilities which had been projected for the professional physical therapist.

1. Interpretation of physicians' referrals.
2. Initial evaluation of referred patients.
3. Development of the treatment plan and program including the long and short term goals.
4. Selection of the appropriate portion of the program to be delegated.
5. Instruction of the assistant in the delegated functions to be carried out: precaution, special problems, contra-indications, goals and anticipated progress, and plan for re-evaluation.
6. Supervision of the assistant.
7. Re-evaluation of the patient and adjustment of the treatment plan with the assistant present and arrangements for reports (written and verbal) for the assistant through the physical therapist to the physician.
8. Provision for opportunities for growth of the assistant through in-service and continuing education experience.

At this point, I would like to ask all of you a question — Is it not true that the physical therapist has been striving for a greater role in decision making as it relates to our profession for many years? These endeavors were motivated by our need for advancement and prestige and the need for a more active role in decision making, in order to satisfy the individual needs of the type of individual that was being recruited into the profession. Our activities and achievements are very clearly outlined in position papers of the American Physical Therapy Association, dated October 1, 1968: Relationship Between Physical Therapist and Physician, Referral Relationships Between Physical Therapists and Physician, and the position paper on the Qualifications of a Physical Therapy Department Head.

The general job description being projected for the physical therapy assistant involves the following:

1. Carries out physical therapy patient care programs or portions thereof, as planned and directed by the physical therapist:
 - a. Accepts responsibility for patient's personal care and environment throughout the treatment.
 - b. Follows established procedures and observes safety precautions in the application of modalities.
 - c. Carries out positioning and exercises.
 - d. Trains patients in exercises, ambulation, and activities of daily living.
 - e. Carries out treatment utilizing special equipment.
 - f. Cares for braces, prostheses, bandages, and other active assistive devices.
2. Carries out responsibilities appropriate to the established physical therapy service:
 - a. Participates in clerical and reception activities.
 - b. Complies with procedures for maintenance of supplies and equipment, and carries out duties necessary to comply with the related needs as delegated to him.
 - c. Maintains surveillance of environmental conditions within the physical therapy service.

While the outline stated above gives one a rather general indication of the role of the physical therapy assistant, it is important that we establish a much more well defined division of responsibility, if this sharing of responsibility is to be effective leading to the highest level of quality with the least amount of fragmentation. I believe that Nancy Watts (3) has most clearly outlined this division of responsibility in her unpublished paper "A Theoretical Model for Task Analysis and Division of Responsibility in Physical Therapy." I understand in talking with Dr. Watts that this paper will soon be published in *Physical Therapy*, Journal of the American Physical Therapy Association. The model projected is one which parallels the general categories outlined above, and analyzes physical therapy services in terms of three major divisions of the task involved:

1. The *process* used in performing the task, categorized in terms of the degree to which it represents decision-making (as opposed to doing) and the degree to which these elements are separable, i.e. can be performed by different people.
2. The *purpose* or function for which the task is performed, categorized by instrumental or expressive.

3. The locale of task performance, categorized in terms of the physical proximity of practitioner and patient, remote or face to face.

The process dimension involves two different components: decision making, and doing. Since physical therapy is a very specific goal oriented service, both of these factors have bearing on our activities. While decision making can be a rather simple intellectual chore, one must also remember that it involves far more than simply recall of information. The decision maker must use a complex series of mental maneuvers, blending such cognitive skills as synthesis analysis, exploration, application, and evaluation. The U.S. Department of Labor, in its dictionary of occupational titles, states, "Decision making skills involve dealing with data, while doing skills require dealing with people and things."

Under the purpose dimension, Dr. Watts identifies two categories: instrumental and expressive. The instrumental function are those which usually receive initial attention in planning and providing services, while the expressive purpose are those acts designed to contribute to the flow of satisfaction of the patient.

The locale dimension is considered by Dr. Watts mainly due to the great bearing face-to-face contact between practitioner and patient has on the ultimate satisfaction of personnel at various work levels. She points out in her remarks that as one progresses in the chain of command this face-to-face contact decreases.

In considering these various dimensions, one must be aware of the fact that very few procedures are truly simple or complex under all circumstances. One must, therefore, be sure to consider all aspects of a treatment situation before making a decision. I have also indicated on a number of occasions in these remarks the fact that there will be definite over-lapping of responsibilities within our delivery system. It is, therefore, of great importance that the therapist not be the super-trained or the assistant partly trained, but that each be trained to fill a very particular role within the delivery system.

The taxonomy of physical therapy tasks, as outlined by Dr. Watts, falls into seven levels of activity:

- Level I** — Largely standardized and routine procedures.
- Level II** — The task can be standardized and call for little instruction, observation, and deal with the most basic procedures.
- Level III** — Tasks are standardized to the degree that only a limited number of alternatives exist and the treatment procedures vary to a very slight degree.

There is some need for observing and recording patient responses which call for limited interpretation.

- Level IV —** Instructions and/or treatment tasks in which decisions about procedure require important and rapid modifications based on observed and interpretative responses of the patient or person instructed.
- Level V —** Tasks which primarily involve formulation of decisions, direction, and supervision of others in the performance of the selected procedures.
- Level VI —** Tasks which involve decisions about whole patterns of activity for groups of people.
- Level VII —** Tasks which have as their purpose the critical assessment or expansion of the theoretic base for decision making in the field.

Where do you feel the line should be drawn to divide the assistant category from the professional therapists' category — Between 3 and 4? Where is the line drawn between the aide and the assistant — Between 2½ and 3?

I do hope I have been able to share with you this morning some thoughts on what certainly is one of the great dilemmas at this point in history. As a profession, we are being challenged to meet the needs of those we profess to serve — the consumer. Will we be able to meet this need? I further profess that the physical therapists of the future, in addition to having a major role in management and decision making, will continue a very active role in direct patient care. Without this experience, it would eventually be difficult for them to continue at the high level of decision making needed in the planning of services for individual patients. In assuming this role, we will also have to challenge our present educational institutions to have them meet the needs of we, the professional community, in the preparation of new individuals coming into the field, as well as direct activity in continuing education.

Possibly, in closing, a prayer written in 1934 by Reinhold Niebuhr is appropriate:

"Oh God, give us serenity to accept what cannot be changed, courage to change what should be changed, and wisdom to distinguish the one from the other."

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Discussion Workshop

ROBERT BARTLETT, PT, M.A., *Chairman*

BARBARA STEVENSON, LPT, B.S., *Recorder*

GEORGE PATTERSON, *Senior Student, in Physical Therapy, Coor.*

According to the taxonomy of physical therapy tasks as outlined by Dr. Nancy Watts (3) in this morning's speech by Mr. Bartlett, there are levels where the aide and the assistant overlap, and areas where the assistant and the professional therapist meet. Should there be a distinct and separate job description for each, or is such overlap advisable?

"When you talk about two people doing the same job essentially, to a degree you are talking about quality. When you get into the realm of quality and you are talking to administrators, they don't buy this quality thing. You can't justify this quality to the people who are paying the salaries; they feel it is the same job and either person can do it. Will they hire the assistant in deference to the cost of providing service, or look for quality service?"

"I think we are really talking about a basic fear of being left out, with nothing to do, in spite of four years of college education and a very distinguishable service to provide."

"I think we do have fears and well founded fears, based on the fact that as our provinces are delegated out, there is no other new prerogative for us to assume. There is no evidence at the moment of any relinquishment of the prerogatives of the

physician. What has been done in the development of the superstructure for the secondary rehab centers is an example. They are putting men in charge who are not psychiatrists, who have only to be a diplomat in any specialty of medicine, and have a required minimum of three months' experience in rehabilitation medicine over a three year period. Medicine has said in effect that these three months give a physician more expertise in rehabilitation than has my whole career in physical therapy and rehabilitation. I don't feel we should close the door on the assistant, but I DO feel there ought to be a door open at the other end of the corridor for US to advance through."

"I also feel there is a very specific body of knowledge that we acquire in a professional degree program. As an example, at the West Seneca State School for the Mentally Retarded, I saw what a group of professional people have been able to accomplish, in directing a program and using a lot of supportive personnel. This is in contrast to what you usually see in institutions of this type, where a gamut of people from varying backgrounds offer what they consider to be a good program in 'physical therapy' for these children. It clearly points out that there is a definite body of knowledge that we have to offer, as teachers, and supervisors, and as professionals delegating responsibility. I think the fear that some people have is basically due to the abuse and misuse we have seen of supportive personnel in some programs of patient care, where the quality of care is not equal to our professional standards. I think it points up something in the system, in the way we use our sub-professional people."

"The medical systems (or non-systems) of today are systems of limitations. It may be true that we therapists are 'over-trained' for many of the things we do in patient care, but I have the feeling of some individuals within Allied Health Professions that we stay in these endeavors because we are not allowed to take a more active role in the decision making at a higher level, and we see a trend on the part of some physicians to take more away from the therapists at this higher level. There has to be a sharing of responsibility at the higher levels of health administration as well."

"We have been very provincial here today; are we being unrealistic in anticipating a realignment of responsibility; the physician's assistant, etc., does this relate to us?"

"Probably things are changing, and nobody likes to change, but PT's are doing things they didn't do ten years ago. Nurses are not having the problems, the antagonism that PT's are having in working with physicians' orders. Nurses are monitoring cardiac beats, blood gases and analysis, and other technical skills. It

is partly the law of supply and demand. We are going to have to be better professionals, not entirely therapists traditionally — more supervisors, a little step-up from doing it yourself. The medical profession is going to see this, and the smart ones are going to say 'This guy has skills I can use now that he didn't have before and maybe the time to do things he didn't do before', and they're going to use us. You can't legislate it, rules aren't the whole thing; you can't become a more professional-professional solely on the basis of rules."

"Part of this may be true; the physical therapist has not been trained in school to be a problem-solving type of individual. If he has been trained to be a problem-solver, he need not worry about how much support or lack of support he gets from above or below. Part of this problem goes right back to the kind of training, good or bad, the therapist gets in college."

"I think some of our restrictions in medicine arise out of medical-legal liability and this may determine how much we delegate. This is one of the things we need clarification on and need to take a stand on, in order to give us the freedom to designate assignments."

"This is one of the areas under investigation; right now the therapist feels that if he has supportive personnel working in his department, the therapist is the ultimate responsible person for what goes on in that department. A lot will depend on the licensure and certification of this new category, where the assistant is placed in the medical-legal milieu."

"The basic problem is that we do not have enough people to do the job; you can't legislate it, you can't write rules if you are going to meet the challenge, it is up to you and the assistant. Some assistants are going to be better than the four year graduate and some are going to be just awful, and it is going to be up to you as managers how you are going to get along with them. You are not going to take some list from the APTA and say to the assistant, 'You can do this, but you can't do that'. There is going to be pressure from administrators who are trying to save a few hundred dollars, but, is the pressure going to be that great? Is the pay difference going to be that great?"

"It seems from our past experience that some of these things are going to be spelled out for us. We are going to be burdened with the remunerative formula problems and people will be telling us that certain types of activities will be delegated by virtue of the money value put on them. Until you put some sort of measuring device against these tasks, who can do them and who will do them, this will determine the money value. At

that stage it will be very clearly spelled out for us, in the cost analysis, who the aide is, who your assistant is, and who your volunteer is."

"The OT this morning was saying that she is constantly bombarded by agencies about what are the specific duties of the assistant as compared to the professional; it is not we but *other* people who find difficulty in defining the assistant, and who need the guidelines to understand what exactly are their respective duties."

"We cannot use other professions or the labor market as a model to define roles, because we will get into the same dilemma as many of them, where one worker cannot reach over and push a button because that is someone else's prerogative. That is what has driven costs up, and we are trying to keep costs down, while providing quality service; it wouldn't contribute to better patient care."

"We should first determine what it is you are doing and make sure it is optimal, and then break it down into the best way to provide this patient care, and then determine by job analysis who is assigned to specific tasks."

"My problem with the task analysis is that you have to be careful that it doesn't impart a rigidity, pigeon-hole a guy, drawing hard, fast lines around his function. You just want to be sure that the job analysis doesn't just justify a pecking-order attitude."

"One of the problems in assistants' roles and aides, too, is recognition for years of experience and desire for self-improvement, but they are locked in a dead-end. Aren't we trying to take care of this by planning school curricula to permit the assistant to go on? Isn't this the assistant's flexibility?"

"The Med Techs are now implementing equivalency testing for those persons with the motivation to go on with the capacity to do so. The option remains with the school as to what courses can be waived on the results of these tests and let the assistant pursue a higher level of education and certification. PT is a couple of years behind, but it is going to be a fact of life within five years. I am not so sure about OT because they have followed a different course on licensure, etc."

"As we learned yesterday, there isn't going to be a large influx of these assistants right away (313 next year, from 18 schools; 600 the following year; and 15 last year); there will be a gradual assimilation of these people, and there won't always be the problem we are facing today. We will learn gradually how to work with these people to the best advantage."

"It is in the eye of the beholder that he becomes whatever he is. It is the supervisor's responsibility to have an attitude of open acceptance and let in the assistants and let the assistant do many other things, not just adhere to the limitations in the title."

"The attitude held toward the assistant is very important in effectively working with the assistant. We have aides already; we are not going to attract the caliber of people we want in patient care unless we give them the opportunity to grow and share some responsibility."

"Aides under my supervision have specific individual capabilities which I can use in my department. Some can make judgments and work relatively unsupervised and others cannot. Interestingly, they have all been trained under the same program in my department."

"The team unit concept has worked very well in some facilities, by virtue of good coordination. The one who had the best rapport with the patient, or who had the major role to play in the rehabilitation process affected the whole program. And no one profession felt resentment, it was the patient and his progress that mattered the most, and often the assistant was the main 'rehabilitator'. A well functioning team is that group which shares the decision-making and makes suggestions, and in which there are no problems of leadership, who is in charge."

"This is effective management, and the same judgment factors apply to the PT assistant or your graduate staff."

"Are we really putting ourselves into a pigeon-hole, training PT, OT, speech therapists and others separately? Why not train one person to do the whole thing, be a 'rehabilitationist', utilizing supportive personnel who are trained in specific, refined tasks? In small, rural communities the physical therapist is the whole program, doing the job of all these other specialists."

"For that matter why not train Health Assistants in all the background skills needed by PT, OT, etc. in common, in a two-year program, and then he can choose where he would like to go, or can be assigned where needed. With these basic skills he can receive the rest of his training on the job."

"Is junior college level education necessary or appropriate for these people—since you fit them into the job you feel they are capable of anyway?"

"Yes, it gives them greater mobility, to move from one job to another, from one type program to another with a minimum of training. Aides now are trained for specific programs, on the job, but they lack the mobility afforded by a higher grade of

education. Also, you can maintain certain standards and levels of course content in accredited colleges that you cannot guarantee with on-the-job training. Universities will not give academic credit for non-accredited programs, and so the person trained on the job lacks social and economic mobility."

"Some facilities through in-service education and even courses, such as English, are encouraging aides toward the associate arts programs, though no academic credit is given as yet."

"Equivalency testing, if proven valid, might take care of such problems for both the aide and the assistant, and the corpsman returning to civilian life."

"We are going to have to have a different basis for recruitment into the profession. People who are generally attracted to patient care have been the basis for our appeal. Will this now have to change, will we attract a different 'breed of cat' to a different kind of patient care from the laying on of hands?"

"The way we attract them may have to change but basically the same kind of person will be attracted. The prolonged patient-therapist relationship might not be there but the patient is still the focus of the professional therapist."

"Several of us got out of patient care and into administration. Someone yesterday remarked that a lot of people leave the field because they got little satisfaction from patient care after all. People who go into health administration do have satisfaction through what they feel they can motivate through the administrative structure, but they will still be the high caliber, altruistic kind of person we attract now."

"Assistants are prepared for functions about which they know very little and are being hired by individuals who know very little about them. Supervisors, then, should open the door and ask the assistant 'who are you?', and make every effort to make him one of the most useful, contributing members of the patient-care staff. Give him some kind of status in patient-care."

"The professions should have a degree of flexibility; people are coming in to assume very definite duties, not just our 'gut work'."

"Some of the task analyses will guide judgments in the best use of ALL levels of staff, regardless of specific titles."

In summary, these verbatim questions and responses regarding the physical therapy assistant reflect the effect of change on ours, a relatively new profession. At the same time we are pushing at the limitations imposed on our profession, the assistant is arriving to help us but is also adding to our responsibility.

ities. As we look to the other professions represented here today at this Conference, there is no one model of utilization which deserved to be copied in its entirety.

The conclusions to be drawn are:

1. The demand for physical therapy services exceeds the supply of professional physical therapists; we need help of high quality to meet the needs of our patients.
2. Since we as physical therapists know most about what constitutes optimal patient care in physical therapy, we must prepare to be good managers and provide this care in a quality program of *shared responsibility*.
3. This level of shared responsibility will be determined by job and task analysis, and the degree to which we have flexibility, humility and respect for the individual, not just by the limitations imposed by certification and/or licensure.
4. To maintain and attract a high caliber supply of supportive personnel, we should plan ahead and provide avenues of educational and job mobility for those aides and assistants who have the competence and motivation to outgrow the restrictions of the job title.
5. The education of the professional must now include added emphasis on supervisory and managerial skills, problem-solving in addition to our traditional role.
6. Physical Therapy still has a definite role to play despite the fragmentation and stratification of health services; we know more about physical therapy than any other group. If we assume this attitude and can prove it, we have nothing to fear from those above or below us, in the changes ahead.

Rehabilitation Counseling and Support Personnel

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The concept of an "all-purpose counselor" for each and every client needing help is probably obsolete, certainly in numbers, if not in kind. In order to provide the amount, type, and level of help needed by thousands of clients, new delivery systems are required which involve re-thinking the helping modalities of the past. DiMichael (1967, 1968) suggested that new actions are required so as to provide a new and more effective alignment of current skills, and at the same time improve the functioning of personnel in our established positions within rehabilitation. Persons from different backgrounds, experiences, and training levels are necessary to provide all the service clients require. Various titles have been used for persons performing these functions, such as rehabilitation assistant, aide, technician, para-professional, non-professional, and indigenous counselor. Within the counseling field the general title of support personnel has been used and accepted. This title has referred to those persons functioning in auxiliary roles to the professional counselor. There are generally four types of support personnel whose functions or roles can be defined as follows:

1. **Clerical** — To assist the professional with tasks of report forms, record keeping, scheduling, following up on appointments, referrals and information gathering.
2. **Indigenous I** — Cultural — To act as liaison to the rehabilitation community or agency as a result of belonging to

racial, ethnic, or other cultural groups.

Indigenous II — Experiential — To assist by virtue of intimate experiential expertise on specific life problems such as alcoholism, addiction, corrections, blindness, etc.

3. **Technician** — The technician or assistant job calls for judgments based on knowledge, principles, and skills, though less complex than required by the professional counselor. Education of this type might be at the community college or baccalaureate level. Persons with this training can function as intake interviewers, evaluator assistants, community liaison, and in placement and job development, in special education and rehabilitation facilities, and agencies.
4. **Aide** — Persons who learn on the job or in an apprentice-like supervised situation to carry out specific jobs, usually of a routine nature. The training period required to do the job is short — usually several months.

Support personnel have been found to be selectively able to develop interpersonal skills so as to work effectively with clients in a variety of situations and settings (Peckham, 1969, Truax, 1968).

Rather than concentration on what is properly the counselor's role or job, focus might more constructively shift to attempting to conceptualize the total helping process needed to solve specific client problems. Such a focus will require the helping person to engage in a number of psychosocial tasks in collaboration with other helping persons and the client in order to engage the client in problem-solving behavior. The psychosocial tasks to be performed in this process will require the use of a number of modalities of help performed by persons with different life experiences, training, and educational levels. The emphasis should be on joining together different points of view, knowledge, experience, and skills. The solution to client problems rarely is within a single discipline or profession. Solving client problems might better be approached from multi-dimensional professional strategies rather than from the traditional uni-dimensional professional approach.

The issues, then, are not counselor, coordinator, social worker, psychiatrist, support personnel, or professional. But all are necessary. The entire helping process requires that all of these persons and types of services be organized into a total context of rehabilitation strategies to meet specific client problems.

One of the differentiating qualities of rehabilitation as a system has been its total concept approach to care, though refinement and delineation of this concept are required. In fact, the development of our philosophy into concrete treatment strategies

seems to be where we are at. The question then is, how can we operationalize this total care or helping concept through defining specific psychosocial tasks required for client problem-solving?

Some task performance is necessary to help a client get started in the rehabilitation process before the specific service stages can begin. These early readiness phases have been neglected, both in the literature and in practice. Some of these readiness tasks are:

1. Locating the client (out-reach function)
2. Coming together of client — counselor — agency (initial referral and continuing contact)
3. Establishing the credibility of the service or agency (requiring evidence, usually immediate, that *action and deeds*, not *words*, or *promises*, are operating procedures)
4. Communicating with the client in his language and within his field of experience, understanding, and values (indigenous help)
5. Demonstrating what is possible by making future goals *desirable and concrete* (motivation and support)

If these initial "tests" are passed, clients may be able to make a commitment to the helping process and only then are the secondary service stages of rehabilitation effective.

The typically educated professional counselor generally has difficulty in performing these primary functions. Persons from different backgrounds, experiences, and training levels are required. Helping professionals have tended to exhibit a bias in favor of their own middle class modes of thinking, feeling, speaking, and behaving. However, the preoccupation with middle class values prevents effective communication and interaction with clients possessing different values and life styles. In fact, the subtle rejection of differences has influenced the make-up of counselors' caseloads and differential treatment has been documented for those stereotyped and labelled deviant (Derbyshire, 1969; Hollingshead & Redlich, 1958; Kriegel, 1969; Lewis, 1969).

To gain understanding of the world of the deviant will require more concentrated attempts, not only to deal with psychological dynamics of each person, but to view the world of the person from "the inside-out" to the larger social and cultural context. This requires both a broadening of our knowledge base and different types of life experiences within our helping teams. We may be able to escape our ethnocentric tendencies by effective use of support personnel.

The life experiences in and of themselves which support personnel may contribute to clients and to professional counselors

alike and may provide a richness and a new dimension to the rehabilitation process. Understanding brought about by "living the problems" brings a reality and perspective not otherwise available. For example, perhaps the experiences of coping with the problems of alcoholism or addiction may be understood in all their depth only by someone who has shared these types of problems. Commonality between those who have been in similar life situations permits more open communication, provides coping models, as well as goal directions for clients.

Support personnel are needed, therefore, not only to perform tasks with clients that middle class graduate counselors find difficult, if not impossible to perform, but also to help supply the quantity of helping persons needed in rehabilitation. The crisis nature of manpower shortages in the rehabilitation counseling field has been well documented (McAlees & Warren, 1966; Smits, 1964). The supply of Masters level counselors is insufficient for agencies to carry out their legislated mandate. On the basis of manpower supply alone there is no choice, as Bregman (1969) has pointed out. However, another important reason for the use of support personnel is the fact that the training and skill of Masters level counselors are under-utilized. Time is too frequently spent in task performance not requiring a Masters degree training — while more complex tasks go unperformed (Social and Rehabilitation Services, 1968).

In summary, support personnel seem essential to the rehabilitation counseling process in order to (1) perform functions that graduate level counselors cannot perform, (2) add new experiential dimensions and coping models, (3) provide the increased numbers of personnel required by the field, and (4) utilize and develop the maximum level skill of the graduate counselor.

A compelling approach to the development of the support personnel concept is the plan referred to as New Careers. The New Careers Model resulted from the 1968 amendments to the Vocational Rehabilitation Act and purports to recruit and train individuals who are, or have been, deviant or disadvantaged clients for employment within the service structure of the rehabilitation agencies. Inherent in this model is the concept of the career ladder which provides the opportunity for upward mobility into jobs or careers with progressively higher levels of skill and performance requirements.

The National Rehabilitation Association is involved in a demonstration project entitled, "New Careers in Rehabilitation." Its purpose is to disseminate information, study the implementation of the New Careers concepts, and develop guidelines for its use within the rehabilitation service context. Generic models of

job descriptions and career ladders are being developed for use in state agencies, with technical assistance from the National Institute for New Careers. The New Careers provision is not intended to be just another manpower program, but involves the development of New Careers jobs and opportunities in human services with possibilities for vertical career ladder progression (Klein, Denham & Fishman, 1968). The NRA project is involved with the study, definition, and development of New Careers programs for rehabilitation.

Perhaps the most critical need in implementing this concept is the attitudinal acceptance of support personnel generally, and "new careerists" specifically, on the part of professional counselors and other rehabilitation personnel. The findings of Muthard and Salomone (1969) indicated that rehabilitation counselors were reluctant to share any but routine, repetitive job tasks with support personnel. Information and careful planning in which counselors and other rehabilitation staff are involved should precede the introduction of support personnel into agencies and facilities. Counselors should gain the understanding that their work with clients will not be threatened, but rather be extended in its effectiveness by collaboration. Counselors will, of necessity, need education and training in supervision of the support worker. Supervision will become a new aspect of the counselor's role. Reports of the need for, and the effectiveness of support personnel should be an encouragement to counselors and agencies alike as improved counselor morale, client trust and progress, additional clients served more appropriately as well as heightened community respect, are usual reported outcomes (Griswold, 1969; Peckham, 1969a, 1969b; Truax, 1968).

EDUCATION AND TRAINING

Several types of education and training for supportive service systems have developed; at the baccalaureate level, the community college level, and on the job training. An experimental undergraduate curriculum, Rehabilitation Education, was started at the Pennsylvania State University. The curriculum provided both a terminal program for students wishing to prepare for entry positions in various rehabilitation areas upon graduation and a pre-professional program for students wishing to prepare for graduate specialized study in a broad array of health and helping professions. The curriculum encourages a broadening of the students' occupational perspectives and includes an understanding of man as a physical, social, and psychological being. A base may be built for later inter-disciplinary teamwork and communication through understanding of the broad principles of a common

philosophy and a fundamental preparation in the disciplines underlying provision of rehabilitation services (Hylbert, 1963). The Pennsylvania State program has served as a stimulus and prototype for the development of undergraduate programs at a number of other institutions.

At Middlesex County College a Rehabilitation Assistant Education program leading to an Associate in Applied Science degree was developed in 1968. The students are prepared to work with professional personnel in public and private health and helping agencies and facilities. For those not wishing terminal preparation, the program serves as a broad base for higher education. Curricular content includes both broad social science and education courses, theory and philosophy of rehabilitation, and supervised practice in rehabilitation and welfare agencies, centers, workshops, hospitals, and economic opportunity and community action programs. The potential roles and functions of the rehabilitation assistant include specific tasks in the areas of case finding, intake, service provision, coordination, administration, placement and follow-up. The possibilities for employment continue to expand as agencies and facilities develop career ladders providing job classifications for associate degree level personnel (Nagy, 1969; Middlesex County College Catalog, 1969).

The allied health professions have preceded the helping professions in recognizing the needs for support personnel in delineating their functions, training them and integrating them into the health service systems. In addition, allied health services have given attention to the necessity of developing career ladders for the various areas of the health services. Programs are being developed to train leaders for the education and supervision of supportive personnel at all levels of higher education, including the community colleges, baccalaureate and graduate programs (Perry, 1969a, 1969b, 1969c). The collaboration of the health and helping professions is essential in the development of comprehensive rehabilitation. I would like to put in a plea for the joining together of these areas in our programs and most particularly in the training of new staff so as to prevent separateness in a new generation of professionals. Basic generic training should in addition diminish fragmentation of services. New ways of integrating these systems at different levels of training and experience must emerge at both the community practice and the university pre-professional levels.

Rehabilitation counseling must give more attention to preparation at a variety of levels so that we truly have a career ladder. Such a comprehensive ladder would start with the rehabilitation aide having limited training on the job, and include the rehabilita-

tion technician trained in the community colleges, and the rehabilitation professional educated at all college levels — Bachelors, Masters, and Doctoral.

How to align these functions, tasks, and outline the specific training for each level is our current task. At least four organizational models to introduce support personnel into the counseling enterprise have been identified.

1. **Counselor unit** — This model provides for the counselor retaining his customary role of continuity with the client through the whole counseling process. The support person is introduced into the unit for specific functions under counselor supervision and direction.
2. **Supervisory unit** — In this model the support personnel serve several counselors under the direction of one supervisor. The supervisor is responsible for the coordination of both the counselors' and support personnel activities in this unit. The counselor continuity with the client is maintained.
3. **Vertical specialization** — This model provides for the rehabilitation process to be divided into functions such as evaluation, counseling, training, and placement. Counselors would be responsible by area of specialization with support persons assigned to them to carry out duties within the particular phase of service.
4. **Support personnel unit** — In this model the support personnel carries his own caseload and is responsible for carrying out all counseling functions. His work is reviewed, guided, and supervised by the counselor. The counselor and support staff work in parallel fashion to each other. Peckham (1969b) describes cluster counseling in referring to aides working in the inner city. Each aide works with a caseload of five from out-reach to completion, handling clusters of clients with clusters of services. A group identity is established rather than the usual one-to-one relationship. For example, the aide will gather his five clients in a car pool for going to group counseling, or group medical examinations, or group placement in a given work area. The aide drops out of the picture when the group buddy system has developed and a pattern of shared responsibility is established. But during this time the aide is in complete charge of this cluster group.

A study by Truax (1969) indicated that counselor aides had the greatest benefits for clients when they handled entirely their own caseloads supervised informally on a one-to-one basis by professional counselors. The research further indicated that when

aides were used as assistants to the professional counselor serving his caseload, the poorest client benefits occurred with some indications of negative effects. It was also reported that under this informal one-to-one supervision no role conflicts occurred between the professional counselor and the trained practical counselor.

It would appear that a model of *community-centered team counseling* is emerging (Jaques, 1970) as a work role within rehabilitation counseling. The counselor in this model will act in concert with persons of different training and life experience, in neighborhood multi-purpose centers and in more traditional settings. This approach will provide direct and supportive services, crisis and environmental intervention, socialization, developmental work conditioning and therapy (evaluation, training, and placement), as well as psychotherapeutic counseling, when required.

Community-centered team counseling should involve the creation of a continuum and a continuity of services of which clients could partake freely, without the real or perceived stigma which has accompanied the receiving of services and help in the past. The helping process in this paradigm is conceptualized as the totality of psychosocial tasks required to move a client from a state of relative dependency to one of relative independency on a higher functioning plane. Independence in this sense is not a fixed goal for everyone such as a job, a diploma, a college education, but the highest degree of functional ability possible for the individual within the context of his total life situation and value system. Psychological tasks arise out of the specific and individual problems of each client. The range or repertoire of counseling behavior would vary by client need, agency resources, and counselor capability for definition and deployment of the treatment strategies required. Client-defined goals become the primary criteria for performance, and establish the direction for the program effort.

The question no longer is shall we use support personnel or not, but rather how shall they function, be trained, and supervised. Both limited experience in the counseling profession and that of other fields has shown that professions are not downgraded by the introduction of persons at different levels of function, training, and experience. Rather, it will make our work more vital, interesting, and helpful to clients and to society alike.

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Discussion Workshop

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 BETTY MURPHY, MT (ASCP), B.A., *Recorder*
 PAUL SCHRECKENBERGER, *Senior Student in Medical Technology, Coordinator*

The workshop moved readily into the critical issues by inquiring as to whether support personnel were needed in all areas and, if not, what areas were functionally amenable to such assistance. There seemed to be general agreement that the clinical areas would, indeed, need the services of assistants. There were serious doubts as to the real contributions such persons might make in the area of psychiatric counseling.

This seemed to lead into the "treating of the whole patient" concept. Some real concerns were expressed to the effect that at present the whole patient treated, albeit by a "team" of counselors (rehabilitation, social, psychiatric, etc.) and that the introduction of less qualified assistants would tend to fragmentize the treatment process to the detriment of the patient. The solution might be found, it was suggested, in the putting together of a staff which would serve all of the patient's needs and include therein as many assistants as a functional analysis might show to

be contributive. There would be need, it was felt, for a generic base for all professions and that all would have to work together or risk professional stalemate and "bogging-down".

The use of indigenous personnel was looked at to some degree and with this discussion came the issue of vertical mobility and its base in middle class standards. Those people may not see value in "upward" mobility as it is popularly perceived and may well see their primary value as residing in carrying out functions which were not "open" to other professionals and from which upward mobility might remove them. This was amplified by the expressed fear that we may well contaminate the indigenous person by educating him to our ways and decrease his efficiency with his own people. One member suggested that we should go to the communities, find out how they function and what their needs are and "plug into" their system rather than fabricating a new one, unfamiliar to all.

Who benefits most from the services or presence of an allied health professions assistant? The professional? The patient? The assistant? A response to this provocative question was slow in coming and was approached from many directions. The single consensus-hook appeared to be that of the legal hassle as it restricts function and it was agreed that the agencies involved with services cannot carry on as required by law because the consumer is not getting the services which are *legally* his to expect. That it is impossible to provide services as required by law with present personnel appeared to provide the real positives to the need for assistants in patient care delivery.

This far-ranging discussion of need for personnel gave meaningful rise to need for services and the issue of preventive counseling held the group's attention to the concurrences that: (a) the future needs of society should be approached from the angle of preventative counseling; and (b) that there is a need for enough personnel to reach people before they are in extreme difficulty and, thereby, prevent serious situations from developing.

The models of counselor, supervisor, vertical and supportive personnel introduced in Dr. Jaques' paper were referred to from a question of preference. The group seemed to agree on the premise that one model might not suffice for all situations and that all or combinations of models should be employed to meet varying needs. Studies were cited on the role and function of rehabilitation counseling and the timing appears to be right for using the findings of these studies and for increasing people-to-people contact to the improvement of patient care.

Working With Others for Patient Care

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Colleagues and friends — I am about to set the parameters of a battlefield! Probably no question of assistantships has been as violently controversial as that in nursing.

Caring for people has broad boundaries and because those boundaries are illdefined, the question of caring for people who are ill is one to which many groups address themselves. Nursing, consequently, has a struggle not only within its own group but in its many external relations to define what nursing is and who is competent to do it. But perhaps the real question of assistants is assistance in what capacity? What does the nurse need to help her to utilize her knowledge and skills effectively?

I believe that we need to look primarily at the *management* function of patient care, rather than the *caring* function for most of the assisting support . . . and to look more at the concept of the "assistant to the nurse", rather than confine ourselves to the "assistant nurse".

The Legal Status of Nursing

The law defines three groups of nurses who are able, by right of preparation, to practice independently within the definition of minimum safe practice. These are graduates of diploma, associate degree and baccalaureate degree programs. The practical nurse is licensed to practice, within prescribed limits. The nurse's aid is not licensed to practice nursing. She is an aide

to the nurse but has no legal responsibility for the provision of any service to the patient that could be classified as nursing . . . and therein lies a vulnerable trap in the definition of what constitutes "assistance".

"In order to safeguard life and health, any person practicing or offering to practice nursing in this state for compensation or personal profit shall be required to submit evidence that he or she is qualified so to practice, and shall be licensed as hereinafter provided. It shall be unlawful for any person to practice or to offer to practice nursing in this state or to use any title, sign, card or device to indicate that such a person is practicing nursing unless such person has been duly licensed and registered under the provisions of this article."¹

Better Utilization of Manpower

To more effectively provide the manpower for direct patient care, I would see an upgrading of practical nurses through evaluated placement in associate degree programs and the opening of doors to more effective mobility for the graduates of diploma and associate degree graduates whose own changing career goals motivate them to continue their education into university and clinical nursing specialty programs.

I do not see the nurse's aide continuing in her present status. By law she may not practice nursing. She provides the support functions necessary to the technical and professional practitioners who are responsible for direct patient care.

The support functions need preparatory programs . . . communications and management functions on a rising scale of sophistication are necessary if we are to reorganize our health care systems.

Those who are closest to the patient must have the professional and technical skill to observe, recognize what they observe, and know what action to take. Consequently we must remove from direct patient contact those assisting personnel whose skill through preparation is inadequate to interpret effectively what is seen. Concentration should focus on personnel who are health workers providing support in communication, environmental services and therapeutic equipment. Their tasks would bring to the professional care staff all the necessities to provide professional and technical functions. This would free the nurse to be in continuing direct contact with the patient.

The Expanding Function of Nursing

Nursing has another problem . . . not only the delineation

¹Sec. 6902, Handbook 13. Professional Education. Nursing—University of the State of New York State Education Department.

of assistant functions to her own care . . . but the resistance to efforts to drain off nursing personnel to provide the physician's assistant.

I believe strongly that if the present care systems allowed nurses to practice nursing exclusively, and in relation to what they are prepared to do, the critical need for the physician's assistant would not seem so imperative as it now does to many physicians. The nurse clinician and the community health nurse have long been prepared to provide the services identified in the roster of tasks which have been identified by the American Medical Association. Experiments in the *extended function or extended* role of nurses in community health, particularly in the areas of pediatrics and maternal health, have demonstrated very effectively that the assessment of patient care needs can be made quite expertly by the prepared nurse. We believe this to be an extension of nursing practice, not medical practice . . . and the definition of the nurse's role in the health care system is identified and legally protected in the interests of the patient.

The American Nurses' Association has already announced its opposition to the announced intent of recruiting nurses to become physicians' assistants. At the May biennial convention in Miami, the following resolution will be put before the House of Delegates:

"WHEREAS, the traditional roles of the physicians and the nurse have become blurred and less circumscribed as the demands of people for a multiplicity of health care services have burgeoned; and

"WHEREAS, the acute critical shortage of health professionals will continue for some time to come; and

"WHEREAS, a variety of health careers, supportive to medicine and nursing, continue to evolve in response to health manpower needs; and

"WHEREAS, the supervisory controls, essential to quality health care of people are needed; and

"WHEREAS, the appropriate roles and functions of those emerging health careerists are ill-defined and tend to infringe upon the practice of medicine and of nursing; be it

"RESOLVED, that the American Nurses' Association initiate dialogue with members of the American Medical Association and other professional societies to examine the respective roles of physicians and nurses and those of the supportive health careerists, in order to utilize all health personnel more safely, effectively, productively and economically in meeting the total health needs of people."

The Confines of the System

Nursing in this country long has been locked into a system of health services that is obsolete . . . a system that maintains the illusion that people are receiving care. In spite of this, 690,000 registered nurses find ways to function . . . by abdicating much of the valuable professional knowledge they have to give to others who have limited preparation. The people who are giving nursing care to patients are largely those who are least prepared to observe, interpret and act upon the needs of the patients. Nurses have had two roles . . . nurse and manager . . . and often the manager role has taken precedence. The dilemma is great . . . nurses must be freed to exercise their talents for the benefit of the patient . . . and to find ways to work in close association with others to provide a quality of care that will help the patient achieve optimum health goals.

Because nursing has struggled with the concept of the assistant for a long time, and because legislation also tends to lock in roles in a compartmentalized health care system . . . it seems obvious that nursing has three major tasks . . .

1. to reidentify the function of professional nursing as the major role,
2. to reidentify the technical and assisting functions of those "nurses" who are licensed to practice as practical and independent practitioners,
3. to identify and establish within the health care system those helping functions which are contributory to the total care of the patient and develop programs designed to prepare people for support services.

Within this third category, I see the primary role of the assistant emerging in proper perspective to the patient care team.

Briefly, the reorganization of health care systems, particularly in the hospital and nursing home, should be based on the development of a two track management concept . . . professional care and management support services. Within this area of support service, the assistant we now call the nurse's aide would find the legal function of helper out of conflict with mandatory licensure which restricts the "nursing" function of this helper.

The technical functions of nursing which are now centered in licensed nursing personnel from diploma and associate degree programs would constitute the backstopping activities to total patient care. The nursing team, made up of technical and professional personnel would provide a knowledgeable arm of the health team, through whose services the primary care pattern could develop more effectively.

IN SUMMARY

The assistant role of the nurse is probably more obscure than that of the other health related professions . . . partly because of our undifferentiated licensure. There is a real need for the participants of the nursing team to function on a relatively independent basis with the organization of patient care providing for effective communication between the professional and technical members of the team. There is a real need to identify and prepare health care assistants to support the professional care of the patient through a reorganization of the management functions within the health care services. The personnel needed to staff and maintain the hotel services of the hospital, to provide effective management and backstopping communication systems is a very real challenge as we look at the assisting roles. The need for the assisting services to the physician can only be determined by that group but it must be done in relation to other services in the health care team which are already identified in terms of role and function. This can be done effectively only on a direct communication basis.

Working with others is a vital necessity in providing health care. How nurses work with others now, and how they can work with others in the future rests upon our ability to communicate what we are able to do, what we are prepared to do, and how effectively we can help to develop those assisting health service personnel who will help to provide a better base for patient care. In conclusion, I would reiterate that assisting functions should not derive from professional care functions but should instead develop those backstopping activities which enable the professional to use his knowledge and skills more effectively.

Discussion Workshop

RUTH T. McGROREY, R.N., Ed.D., *Chairman*
HAZEL HARVEY, R.N., M.S., *Recorder*
CHRISTINE ELLIS, *Senior Student in School of*
Nursing, Coordinator

The group concentrated on four broad areas in their discussion.

- A. Educational preparation of all levels of nurses and nursing assistants.
- B. Utilization and distribution of nurses.
- C. Nursing practice.
- D. Future planning for better nursing care for people.

A. Under the present law registered nurses who are dependent practitioners of nursing are prepared in three different types of settings.

1. The Hospital School of Nursing diploma program.
2. Community College associate degree program.
3. College or University Baccalaureate degree program.

Licensed practical nurses are dependent practitioners of nursing who receive their preparation in various settings, (1) the high school program, (2) adult education programs and (3) private schools—most conducted by a hospital.

Another worker in nursing is the supportive type worker to assist the nurse. They are trained on the job, and although they are usually given a title of nurse assistant or nurses' aide, etc., the group was of the opinion this worker should not have the word "nurse" in the title as it compounds an already confused area which has a variety of prepared persons working as nurses.

B. The utilization of professional nurses is a major problem in the delivery of nursing care to patients, and this group felt if there was a proper distribution and proper utilization of nurses, there would not be a current shortage of nurse manpower.

It was felt that agencies who have great shortages of nurses should examine their patient care practices, salary scale, personnel policies, recruitment practices, and staff development programs.

C. There was agreement among the group that nursing must focus on patient needs rather than nursing functions. Patients are not receiving quality nursing care in too many instances and nurses and other health personnel should look at traditional policies and practices within agencies to determine what changes could—should—be instituted to better utilize all workers to bring better service to consumers of health care.

D. The group who met to discuss the practice of nursing agreed that there is an urgent need to improve nursing care practices and the delivery of health services, and that neither nursing, nor any other one discipline alone, can solve the problems of providing health care. There must be a unified approach and a shared responsibility to bring better nursing care to those in need of such care.

Home Health Aides

HARRY SULTZ, D.D.S., M.P.H.

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My invitation to participate in this program suggested that my paper should be designed to elicit reactions and to stimulate discussion. I trust that in my effort to bring what will hopefully be a few fresh thoughts to the question of how to use home health aides most effectively, I do not intrude upon too many professional tabus, jurisdictional disputes and administrative constraints. Since I am not directly concerned with a specific program utilizing home health aides, my provocative suggestions can prompt two kinds of responses. You may feel that since I am not fettered by the details and problems of the daily operation of a program involving the use of home health aides, I can bring to these questions a different perspective and can make the kind of constructive suggestions which stem from an impartial view of the situation unencumbered by personal bias or vested interest. Or you may feel, upon listening to my suggestions, that because I am not involved, I don't truly understand the situation and, therefore, my ideas can be discarded without further ado. With two such delightful and nonthreatening alternatives you can all sit back and relax while I proceed with alarming candor.

The title of this conference contains the phrase, *delivery of care*. We frequently hear and talk about our health care delivery system and as is usually the case with things we have a name for and talk about, we assume it exists. However, it might be more accurate to describe what we have as a non-system rather than a system, even as some do, an antisystem. Repeated in-

stances demonstrate that our "so called" system is geared to denying health care to people who need it most, or to making an obstacle course of the process of procuring care. Those fortunate recipients of proper health care get it far too often by chance rather than design. And in addition, to the perceptive observer, it becomes increasingly apparent that what we call health care is really sickness care.

I believe that the lack of an effective and efficient health care delivery system is the result of two basic problems with such deep roots in our health care nonsystem that we are prevented from making the needed constructive, innovative changes in the utilization of allied health manpower. The obstacles particularly relate to the full utilization of home health aides and even assistants to home health aides. One major barrier to innovation is that those of us concerned with the planning and implementation of health services are often so singleminded in our concentration on the development of a quality service that we disregard whether or not the service encompasses the problem. In other words, we are service oriented rather than problem oriented. The result of our orientation is that we plan services that bite off bits and pieces of problems leaving great voids in the total network which precludes comprehensiveness and the continuity of individual care. Superimposed on this situation are the constraints of administration, real or fancied, with the result that even the people we serve with a wide range of services still have unmet needs. For example, we faithfully adhere to the doctrine of the five-day week that begins on Monday and ends on Friday. But the home health aide, who works Monday through Friday, cannot deal with the problem that exists on Sunday. Similarly, because of the pile up of tasks and patients over the nonworking weekend, numerous mistakes are made in the hospital on Monday. This kind of administrative rigidity places serious obstacles to the development of an effective and efficient health care delivery system.

Another major barrier arises from developments which are basically good. New professional and nonprofessional health workers are emerging onto the scene. Immediately upon emergence, the membership of these fledgling professions begin to build defenses to protect their new-won territory from intrusion by others. They develop professional standards and ethics with the stated purpose of maintaining the quality of care they provide. Actually, these professional standards often materialize into devices first for insuring the profession's self-preservation and only second, for insuring quality of care. Is the intent of many professional organizations really the improvement of standards, ethics, quality, or is it, perhaps, restraint of trade? Many projects have demonstrated that tasks can be performed as well by

people with less training. Note that I said tasks. Judgements are another matter. Can we continue to encumber the effectiveness of health services in these ways in the face of ever-growing public demand for comprehensive care for all segments of society?

. . . . The American Medical Association has proposed a bold new step to relieve the shortage of physicians: its Board of Trustees says it wants to use specially trained nurses in the fee-for-service practice of medicine AMA leaders "think that acceptance of this new type of health professional, into the practice of medicine is the solution" to the need for improved delivery of health care. . . .

. . . . Dismissing the argument that physicians alone should practice medicine, Dr. Ernest B. Howard, AMA executive vice president, says the nurse already is an agent of the M.D. and provides a medical type of service. . . .

. . . . Medical house calls "would again become a reality" and the extension of home services will result in fewer hospitalizations and earlier discharge of patients who are hospitalized. . . . The "vertical mobility" of related health professionals and technicians will be promoted by the plan, since the concept is not limited to the nurse. . . .

. . . . What do nurses themselves think about the AMA's idea? The "unilateral action" of the AMA was "deplored" by Dorothy Cornelius, president of the 200,000-member American Nurses' Association: "It is not the prerogative of one profession to speak for another," she said. . . . "We strongly object to this action by the AMA, that they would attempt to meet the physician shortage by compounding the shortage of nurses".*

I sympathize with Miss Cornelius' objection to being excluded from participation in this decision. But I disagree completely with her assessment of the consequences. Upward mobility of nurses must result in upward mobility of all the allied health occupations drawing from a larger and larger reservoir of untapped manpower.

Our system has been historically and traditionally a treatment system, and consequently it is not only the most expensive imaginable but continues to grow in cost at an alarming rate. Can we afford to concentrate our major efforts on remedial and rehabilitative services when it would be possible to reverse this trend by revising our orientation from treatment to prevention? Nowhere is the axiom that an ounce of prevention is worth a pound of cure more true than in the field of health care. As an example, the home health aide service began as a means to get people out of hospital beds more necessary for the acutely ill and to provide a less expensive form of convalescent care, both worthwhile objectives with which I have no quarrel. The emphasis has been on the acutely ill, the chronically ill, and the disabled.

But suppose we think of the home health aide's role in prevention. Probably the largest group of people severely in need

*"Topics and Trends," *Dental Survey: The Journal of Dental Practice*, April, 1970, 11-12.

of help in any community is the aging. They are not organized, nor do they have a forum from which to publicize their needs; they do not demonstrate, much less riot. Until their illness, either physical or mental, is so acute that care is mandatory, the elderly get little attention. Frequently by the time their need for health care is recognized, the situation has reached a crisis and only institutional care will suffice. Their problems stem from disengagement, the reduction in the quantity and quality of relationships with others, which results in physical and mental deterioration. In a society that equates employment and productiveness with personal worth, nobody has much time for the aging. If these elderly people become a nuisance, heroic efforts are made to institutionalize them — for their own good of course — despite the fact that the psychological shock of premature institutionalization can be extremely detrimental to their physical, social and mental well being.

Now suppose we were to focus our attentions and concerns on these aged peoples' needs at the pre-crisis level, when the provision of care could be simpler and less expensive. How much longer could the elderly person's admission to a nursing home or hospital be delayed? He may only need help with chores such as house cleaning, laundry, shopping, cooking and not personal care. Wouldn't it be far more humane — not to mention economical — to provide housekeeping assistance rather than to displace or misplace the elderly person in an institution? Some may consider it an unnecessary luxury but it is a great deal cheaper than illness treatment. Personal services such as assistance with bathing, dressing, feeding, exercising, planning and preparing meals, transportation to the doctor's office, and shopping are appropriate health aide assistant jobs. Because an elderly person is no longer entirely independent does not justify institutionalizing him when a home health aide or assistant could provide a satisfactory alternative at far less cost in human suffering as well as in money to the community and to the family. In addition such care is a very practical way to provide an integral part of the continuum of health care. But first it must be accepted as a recognized component of health care. Very possibly the health aide and health aide assistant, in working in a preventive capacity will avert more illness than all of the physicians and nurses could possibly cure at a later point on the continuum.

I'd like to direct your attention to another example of how a nonprofessional home visitor with relatively little training could provide an invaluable service which is essentially preventive. Movie actress, Patricia Neal, recently made a short movie based on her own experiences in recovering from stroke. The significant message of her movie was that the real after-care for stroke was not dependent upon the physician, nurse, or therapist but

rather, that the amazing success of her recovery was dependent upon an individual with far less training. The kind of after-care most effective for the stroke patient can be handled by a non-professional who can provide many, many hours of personal contact. Perhaps you are wondering how I can classify such a service as preventive. It is preventive in that it minimizes the effects of residual disability.

... Programs of home health services are moving in two directions — improved services for specific disease entities already on the case load, and development of services for new groups of patients not now generally accepted for care. Parkland Memorial Hospital (Dallas, Tex.) has a program for the management of rheumatoid arthritis in hospital and at home which has clearly indicated a need to modify conventional techniques of care within the home.

... A Public Health Service ... Task Force noted the general lack of services, programs, and facilities for the care of the patient with chronic bronchitis and emphysema. They strongly recommended the development and support of such services, particularly home care programs for these patients.

Many diseases or conditions—some common, some unusual—have rarely been accepted in home care programs. For these, pilot explorations are needed to determine feasibility of home care, and where appropriate to delineate its modalities ...

Attention has been addressed to other special groups. The home care program at Montreal Children's Hospital is an example of services for a specific age group. The major objective of this program is to improve, or at least maintain, the health care of selected children whose condition is deteriorating or whose treatment is failing under existing methods of follow-up care after hospitalization. The service is proving valuable in a wide range of conditions, not only after hospitalization, but as an adjunct to outpatient and emergency room care.

... The Royal Social Welfare Board of Sweden ... emphasized the use of home health aide services for sick children ... "The children who normally attend school or day nurseries or received day care in a family usually have to stay at home when they are ill, even if they only have a slight cold. Working mothers find this a great problem, as they are forced to stay away from work if the children cannot be supervised in some other way. Absence from work not only means reduced income for the mother but may also cause a deterioration in her position in the labor market." One question our country might ask is how to provide responsible care for ill children of working parents when those children must be kept home under care.

Recognition of the need to provide comprehensive medical care for the social as well as medical problems of maternity patients in low income minority groups led to a home care program at Lincoln Hospital in the Bronx in 1965 ... Unlike a general medical home care program, the maternity home care program makes the substandard and hazardous living condition of its patients parts of the treatment and follow-up. Its pioneering aspects consist of sound foundation for preventive health care where logically it should begin, with the birth of the child" ...

There is need to explore [fully] the role of home care in mental health programs. Although some mental health programs, with the help of public health nurses from community agencies, have established services for individuals who have been discharged from mental institutions and

need follow-up care, there is further need for home health agencies and mental health centers to work together to identify common needs and common goals for their respective patients. . . .*

One of the questions that turns up with regularity in attempting to use nonprofessional personnel is: Who should do what to whom? Should the home health aide perform functions that were formerly the province of nurses? Should the home health aide assistant take on duties previously the responsibility of home health aides? Where does one draw lines in the hierarchy of responsibilities? I didn't touch on these issues earlier because I think that in many cases they are ludicrous and arbitrary. Supposedly, the home health aide substitutes for a responsible family member. Actually, it would seem that the home health aide is prohibited from substituting for a responsible family member. She can place the bottle of medicine on the night stand next to the patient's bed but she can't shake out the pill and put it in the patient's hand because that's administering medication, a function she is not permitted. Surely, a responsible family member is not hampered by such obscure distinctions. I am not so audacious as to suggest or enumerate the specific tasks of a home health aide or even the possible tasks of a home health aide assistant to a group, many of whom are far more familiar than I with the daily operation of a home visitor program. What I am suggesting is that we haven't even scratched the surface of the potential for home health visitor's services. The question I would like to raise is one of basic principles. Is rigid adherence to carefully limited responsibilities sufficiently important to sacrifice the valuable services home health aides might otherwise perform?

My limited experience indicates that home health aides are tremendously effective, fulfill a great need, and hopefully are very productive. Perhaps, they should not be judged too severely on the basis of time expended since it is the human contact that is such an important component in the service they provide and that takes a great deal of time. Given the ability to tap the large reservoir of untrained people, who could serve as home health aides or assistants, we could move into this tremendously fertile field of preventive services. I suggest to you that the gains in preventing crises and circumventing placement in an institution will be gratifying and we will have the added benefits of giving large numbers of currently unemployed women a direction and purpose in life. The home health aide and possibly home health aide assistants would be at the lowest level in the pyramid among all the positions discussed in this conference. Because they form the base of the pyramid, the broadest part, the home

*Claire F. Ryder, Pauline G. Stitt, and William F. Elkin, "Home Health Services - Past, Present, Future," *American Journal of Public Health*, 59.9 (September, 1969), 1720-1729.

health aide assistant and the home health aide cover the most area and therefore involve the most people. I would suggest to you that these two new categories of health personnel may very well offer the greatest contribution to the improvement of the health care delivery system of any discipline in this conference.

It will require profound changes in our attitudes to remove the administrative constraints and to ignore the jurisdictional difficulties presented by these concepts. The situation calls for the release of all those traditional restrictions that no longer can be justified in terms of better health service. It is almost beyond comprehension to understand the fact that 95 percent of all the scientists who ever lived are alive today. Their creative and productive minds are making it possible for us to achieve more technological progress in the next 25 years than we have made in the last 2,500 years. One must ask, "Is this progress good or bad?"

I believe the answer to this question depends upon what we do with these developments and the purpose to which we commit the great power and potential that scientific and technological progress has made possible. This is the challenge of progress — the challenge that faces us in the health professions today. Whether we like it or not, these challenges become an administrative matter and must be given serious consideration.

As health professionals we face the challenge of ministering to our fellow man. In June, 1969, the Department of Labor reported that 21,741 professions and occupations were open to the classes graduating from our universities. Fewer than 10 convey the right and privilege of operating on living tissues, prescribing treatment, or relieving the suffering of human beings. For this reason, members of the health professions and the other health services are a group apart. With the rapid developments in techniques, materials, drugs and concepts, members of the health professions cannot be saddled with archaic rules and outmoded methods. As the physicians suddenly decide to let down the bars to nurses and others doing what were formerly physician tasks, so too must this flexibility filter out to all of the allied health professions.

The old order must give way to the new, but in so doing let us preserve what continues to remain valuable, such as our sophisticated treatment modalities which are the best in the world. Now I would like to see us concentrate on some of our most pressing needs of making available the far simpler, but just as important, personal services that serve the cause of prevention and health promotion.

Discussion Workshop

HARRY SULTZ, D.D.S., MPH, *Chairman*
SUSAN JOHNSON, MT (ASCP), B.A., *Recorder*
VIRGINIA CHAMBERS, *Senior Student, Medical
Technology, Coordinator*

The discussion of home health aides ranged over a wide variety of topics from physicians' salaries to the duties of the homemaker.

Many professionals practicing in the field today function to some extent as home health aides and assistants. But the less educated, but equally effective, home health aide could have a niche in delivery of health care. These people shouldn't be functionally frustrated by administrative legalities and formalities which limit their ability to serve people effectively. It was felt that overtraining was as big a problem as undertraining in the professional as well as assistant positions. The trend is toward a downgrading of tasks.

The home health aide or assistant could function as a family member assisting with household duties and responsibilities. As a "family member" he would be concerned and sympathetic to the family needs, problems and environmental situation. Socially, the aide would be a member of the same community, financial class and ethnic group as his client. We discussed the alienation that could result if the job paid well. The assistant would probably move out of the neighborhood and eventually lose his sensibility to their needs. This whole concept could be mutually beneficial if maintained at a personal level. Elderly or disabled families could help each other on their "good days". A parallel was made to pioneer and small town families.

It was mentioned that a major problem preventing success of health care agencies was their preoccupation with tasks and services, not problems.

Everyone agreed that before progress would be made, attitudes must be changed and rules and regulations and restrictions must be loosened. Professionals, as well as their assistants, can not function under a set of unnatural limits of responsibility. In general, the assistant would be "task oriented" calling on the professional for judgments.

The group felt a need for organization of existing trained personnel, facilities and development of public education programs and job training programs which would culminate in jobs. The need is there and the people are available to be trained; it seemed like the problem would be to get the two together.

With changing health care needs and an emphasis on pre-

ventive medicine, the home health aide and assistant should play a major role in tomorrow's health care plans. Insurance benefits should be liberalized for more realistic coordination with these changes.

Health guides were mentioned as people who would serve a small geographical area of their environment strictly as information sources. They would be trained to let people know whom to see for a physical or social problem to get results most quickly and effectively. These were compared to the physician specialist in family medicine.

We felt the need for home health aides and an according change in the delivery of health care. But more basically people called for attitude changes and liberalizations in these directions.

Action Excerpts

F. L. HUSTED, Ed.D.

Action Excerpts is designed to draw references to major issues together in a series of short statements from the papers and workshop notes presented during the Conference. The essence of an interesting or provocative statement can best be savored by reviewing the paper from which it was taken. For that purpose, parenthetical references are made by author's name and by workshop reference.

ON FLEXIBILITY . . .

We need to retain flexibility in our plans and in our attitudes so

that we can adjust to the developing needs of the future. (Endicott)
We need much discussion and education to understand the really significant potential of the assistant . . . (Joachim)

. . . we cannot meet our manpower needs by relying on traditional definitions of job functions for various personnel. (Detmer)
. . . non-traditional approaches to academic admissions ought to be explored. (1B)

The need to clarify job descriptions without losing flexibility within the professions was seen as of greater priority than developing job descriptions which encompass more than one professional discipline. (1C)

. . . there is a real value and need for use of proficiency exams for allowing more flexibility in career mobility. (1E)

. . . are we allowing the roots of the past that were steeped in "healing" to choke out the progress of present day research? (McLean)

There is no evidence at the moment of any relinquishment of the prerogatives of the physician. (DW-PT)

The concept of an "all-purpose counselor" for each and every client needing help is probably obsolete. . . (Jaques)

Rather than concentrating on what is properly the counselor's role or job, focus might more constructively shift to attempting to conceptualize the total helping process needed to solve specific client problems. (Jaques)

. . . the preoccupation with middle class values prevents effective communication and interaction with clients possessing different values and life styles. (Jacques)

I believe that we need to look primarily at the management function of patient care, rather than the caring function for most of the assisting support . . . (McGrorey)

A major problem preventing success of health care agencies is their preoccupation with tasks and services, not problems.

(DW-HHA)

. . . before progress would be made, attitudes must be changed and rules and regulations and restrictions must be loosened.

(DW-HHA)

. . . new categories of assistants require some modification of the role of established professionals, that adding a new category without changing the system is of limited value. (Plenary Notes)

ON PATIENT CARE AND THE DELIVERY SYSTEM . . .

The most important consideration in the development of new assistants should be the enhancement of patient care. (Endicott)
. . . the consumer of the educational products (should) be involved in the educational process as advisors and consultants. . .
(1E)

. . . all health professionals should share in the responsibility for the delivery of health care, and that each allied health profession should recommend to the State the limits of licensure and certification for its members. (1J)

. . . as we plan for the future, increasing consideration must be given to preventive and environmental health . . . (Brown)

. . . all allied health groups should get together to find out each other's roles toward the patient since our common concern is the patient. (DW-MT)

. . . future needs of society should be approached from the angle of preventive counseling (DW-Rehab.)

. . . the reorganization of health care systems, particularly in the hospital and nursing home, should be based on the development of a two-track management concept. . . professional care and management support services. (McGrorey)

Repeated instances demonstrate that our "so-called" system is geared to denying health care to people who need it most, or to making an obstacle course of the process of procuring care.
(Sultz)

. . . what we call health care is really sickness care. (Sultz)

. . . we plan services that bite off bits and pieces of problems leaving great voids in the total network which precludes comprehensiveness and the continuity of individual care. (Sultz)

(Home Health Aides) should not be functionally frustrated by administrative legalities and formalities which limit their ability to serve people effectively. (DW-HHA)

ON EQUIVALENCY TESTING, EXAMINATIONS, ETC. . .

Equivalency examinations have far-reaching implications for health manpower shortages and for career mobility. (Endicott)

A logical extension of the credit by examination concept must be conceived, developed and fostered for the allied health professions. (Perry)

The assistant . . . needs some kind of negotiable credential, so that he need not be retrained if he changes employer. (Joachim)

Equivalency examinations were seen . . . not only as a mechanism for determining eligibility for entrance into degree programs,

but also as the only objective means for evaluating merit for intra- and inter-facility advancement. (1A)

. . . the four-year programs could establish a workable system of equivalency examinations to determine the capabilities of the individual in various fields. . . (1D)

. . . development and utilization of proficiency or equivalency tests should reduce the limitations imposed by academic requirements. (1J)

Equivalency testing, if proven valid, might take care of (many of the problems for both aides and assistants . . . (DW-PT)

ON JOB ANALYSIS, TASK ANALYSIS, JOB DESCRIPTIONS, ETC. . .

Job analysis and job description come before the initiation of new curricula. (Perry)

The definition of a role makes possible the determination of a training program. (Leuallen)

. . . Health care administrators (should) use the fully qualified professional as a consultant in establishing guidelines and typical task descriptions at each level. (1C)

. . . Before assistants can be effectively utilized in the health related professions their roles must be defined. (1H)

The process of task analysis of the entire career line provides the needed information of how tasks are performed, how they relate to patient needs, and the necessary performance requirements of each task. (Brown)

(There is) an urgent need for task analysis and utilization study in order to improve the educational programs at all levels of entry into the field of medical technology as well as more efficient utilization of personnel. (DW-MT)

. . . the specific tasks performed by the assistant in medical records will be determined by his own abilities and level of achievement and by the needs of the institution he serves.
(Enkelis)

. . . job descriptions of all employees must be very clearly stated. . . (DW-MRL)

. . . a good starting place would be to outline the tasks of the several kinds of assistants and to more carefully delineate the duties of the dietitians. (DW-D)

The dimension of quality must be an overriding element as we consider every facet of job analysis . . . (Bartlett)

(The) problem with task analysis is that you have to be careful that it doesn't impart rigidity . . . that task analysis doesn't justify a pecking order. (DW-PT)

ON CERTIFICATION AND LICENSURE . . .

Without exception this task (definition of the assistant role) must be completed as the first step toward any thought of certification or licensure. (Leuallen)

. . . allied health assistants should be certified so as to promote lateral and vertical professional growth . . . (1J)

. . . there appears to be a need for a revision of the requirements for membership certification in the American Dietetic Association. (DW-D)

. . . the ASRT is opposed to licensure as they feel it will result in reduction of individual mobility . . . (DW-RT)

Standards should be set by federal legislation, not state licensure. (DW-RT)

ON THE ESSENCE OF THE ASSISTANT . . .

The assistant . . . is a person trained to do a part of the skilled work of the professional whom he assists. (Leuallen)

. . . it is not we but *other* people who find difficulty in defining the assistant, and who need the guidelines to understand . . . their . . . duties. (DW-PT)

When an assistant is hired in lieu of a registered therapist, he may find himself expected to take on responsibilities beyond his level of training. (Mellinger)

ON MOBILITY . . .

Barriers between and among associations and agencies must be broken down if career mobility is to become a reality for the allied health assistant. (Perry)

There is an apparent lack of foundation on which to build steps for upward mobility based on ability. (1A)

. . . Although academic education appears to be the immediate step being taken to provide upward mobility, it is, in its present form, not necessarily the most practical, advantageous, nor realistic "mobilizer". (1A)

. . . libraries of programmed learning should be developed and made available as a means of "filling the gaps" toward qualifications for entrance into the academic curriculum. (1A)

. . . all agencies should provide their staff with time and opportunities . . . for continuing education . . . (1B)

In order to establish easy upward mobility, it will be necessary to break up the "credential barriers" that are presently stumbling blocks in the system. (1D)

To facilitate mobility the schools should search for the common ground of each health profession, and develop a core curriculum for all health professions. (1J)

Care must be taken that service and management principles develop concurrently with educational planning for mobility. . .
(Brown)

. . . ART could transfer complete transcript if four-year programs would offer challenge course credit. (DW-MRL)

. . . a student should be given credits for the time spent as an aide . . . (Bartlett)

. . . "upward mobility" within the structure of health care is going to be one of the most crucial factors in the success or failure in the restructuring of our system. (Bartlett)

Rehabilitation counseling must give more attention to preparation at a variety of levels so that we truly have a career ladder.
(Jaques)

. . . the assistant will want and deserve an opportunity for upward mobility but will (may) lack an educational base to build upon. (Plenary Notes)

ON CORE CURRICULUM

. . . any discussion of education of assistants or baccalaureate students must include a consideration of "core" curricula and/or multidisciplinary basic courses. (1C)

. . . we should identify our common bodies of knowledge and formulate a core curriculum. (1D)

In addition to the transfer of credit value of such courses (core courses), (they are) vital to the team concept when studying together leads to mutual appreciation and basic knowledge of each other as individuals. (1I)

(It is) . . . time to design a core program of basic education for all health professionals . . . (McLean)

The education of the professional must now include added emphasis on supervisory and managerial skills, problem solving in addition to . . . traditional role(s). (DW-PT)

ON RELATED ISSUES . . .

Local dollars will have to foot the major part of the bill for allied health training. (Endicott)

. . . any design for utilization of assistants requires that institutions first design a method of recognizing employee ability. (1A)

. . . administrators might well use the consulting services of qualified allied health professionals in the planning-to-hire phase. (1B)

(There is) . . . a critical need for courses in supervisory administrative principles and techniques on the baccalaureate level as well as learning experiences designed to provide the student with an understanding of role relationships. . . in the health sciences. (1B)

. . . the baccalaureate curriculum should include orientation to the discipline of education. . . (1B)

. . . incentive for financial and other advancement might well rise out of better recognition of satisfactory or superior service. (1C)

Recruitment (for the health professional must begin at the 6th, 7th and 8th grade level . . . (1E)

. . . major effort should be initiated to educate parents to the field of allied health. (1E)

A real need is being met in the rural areas . . . by the excellent correspondence courses in medical records. (DW-MRL)

. . . the youth and freedom of this health profession (Dietitians) mark this as an appropriate time to take a strong lead. . . (DW-D)

. . . they (doctors) should . . . be consultants in the area of setting standards for the education and training of technologists and technicians. (DW-RT)

NOTES ON PLENARY

	Panel I	Panel II
Moderators:	Veronica Conley	Thomas Hatch
Recorders:	Charles Ford	John Fopeano
Coordinators:	Sister M. Ardelle DeClerck, Senior Student, Community College Teacher Program	Suzanne Kelsey, Senior Student, Medical Technology

Underlying the discussions in the areas covered by the Panel Plenaries was recognition that the delivery of health care has identifiable faults, some of which could be corrected by the proper use of additional personnel with abbreviated educational preparation. It was recognized that new categories of assistants require some modification of the role of established, professionals; that adding a new category without changing the system is of limited value.

One of the faults in health care which came up repeatedly is the poor communication between the potential consumer and the provider. The barriers are both social and disease related. Assistants recruited from the predominant ethnic or economic group to be served or from the population of rehabilitated alcoholics and addicts would come into the field already knowing the patient's side of the story. Such assistants generally trained can function as translators of medical information for both the patient and professional. There was discussion of how much independence this type of assistant might have. It seemed important that he be primarily a spokesman for the consumer. In this relationship the professional is superseded by the assistant to the extent that the assistant identifies the need and calls for the services of the professional, perhaps even evaluating the end result of the service performed.

A second underlying fault in health care around which much discussion centered was inefficient utilization of the special talents of existing health professionals. In areas of health care which involved physical tasks it was recognized that assistants can often be trained in a short time to perform the task even more efficiently than the professional.

Some caution was expressed however that the highly specialized assistant might fragment care even more. Some also thought the assistant will want and deserve an opportunity for upward mobility but will lack an educational base to build upon. At the other end of the spectrum for solutions to better utilization was the suggestion that the professional's role should really be one of direct care and that the need for assistants is in administrative backup. Those fields which have only lately begun to use assistants see the role of the professional as increasingly supervisory, but are concerned about the attractiveness to new recruits of the image of the health professional who does not "lay on hands." Nursing which is already heavily involved in the use of assistants offers warning signals that the upgrading of the health professional to an administrative role does not necessarily increase the quality of patient care in personal satisfaction in the health career.

Other themes ran through the discussions, often in the form of questions. Who can best initiate change? How can functions be defined sufficiently to differentiate assistants from professionals without unrealistic restrictions in the assistants' ability to grow with the job? How does one keep an assistant from "exercising judgment" if this is the exclusive function of the professional? To what extent are the law and the restraints of third party payment systems limiting worthwhile innovation?

All speakers agreed that no one discipline can solve even its own problems in isolation.

The conference brought into focus the need for individuals who can synthesize new patterns of care from the isolated approaches which the individual professions have tended to promote.

Because of short training periods health care assistants can be mobilized quickly and in large numbers to reflect changing needs and expectations. Properly utilized they can add a humanizing element to the delivery system and add worth to their own lives as contributors to the health of others.

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